## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	of Maryland /	Department of Certificate o		and Mental Hyg	giene 0   2	32001	
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  Clavence Dougle 4a. Facility Name (If not institution, give street and the street an				2. Date of Dea Month Septemb	th Day Year	2 3,30 AM	
	Examin	er	Loch Raven Community L	iving Cen	ter BAI	TIMORE	]			
П,	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F	7. Age (In yrs. last b	oirthday) If Under 1 Yea Yrs. Months Day		24 Hrs. 8. Date of Birth (Month, Day JAN 3,	1926 M	irthplace (State or Foreign Country) ARYLAND	
vland	MON MI		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits	
ne Man	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Heelth and Mential Hygiene. Depertment of Heelth and Mential Hygiene. Important: if time IZ1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination at the notified at once.	Director	MARYLAND BALTIMORE			MARSH			1 ☐ Yes 2 XNo	
with		i Dire	10e. Street and Number 321 LORELEY ROAD		10f. Zip Code	• 21162		10g. Citizen of What ( UNITEL	Country?  STATES	
<b>036</b> urs after deatl		by Funerai	Armed	cedent Ever in U.S. Forces? 2 DNo Give 1950-5	1 □ Vec 2 □ N		igin? (Specify Yes or No- n, Puerto Rican, etc.)	Black, Wh	nerican Indian, nite, etc. BLACK	
15-0036		eted	15. Decedent's Education (Specify only highest grade complete		a. Decedent's Usual Occ (Give kind of work dor	ne durina mos	at of working	16b. Kind of Busines	ss/Industry	
2121;		To Be Completed	Elementary/Secondary (0-12) College 12	(1-4or 5+)	`life. DO NOT use reti			US POSTA	L SERVICE	
Maryland			17. Father's Name (First, Middle, Last) UNKNOWN				er's Name (First, Middle, CCA SMITH	Maiden Surname)		
Mar.			19a. Informant's Name/Relationship (Type, Print) BARBARA SMITH / WIFE				er or Rural Route Numbe WHITE MARSH			
ore,		, i	20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal fro	20b. Place cemet	of Disposition (Name of ery, crematory or other p	place)	Date	20c. Location - City	or Town, State	
altimore,	ertment ortant: injury c		`4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee	GARRI	SON FOREST		09/24/2012	OWINGS M	IILLS, MD	
B B	Depertment of the permanent of the perma		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  LISA SCOTT FUNERAL HOME, P.A.  552 LEWIS STREET, HAVRE DE GRACE, MD 21078							
	within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physicien and the policy filled in by the funeral director, page 2 should be detached for use as the burial-transit.	V 0	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final	each line.	. /	) ,	N .	rest,	Approximate Interval Between Onset and Death	
1			disease or condition resulting in death)	ulmo	navy vi-					
		ē	Sequentially list conditions, if any, leading to immediate Due to	ON OVY /	greery V					
ecuted		Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due t							
760,		cai E	d	- Or j.						
O. Box 68 he death certifica		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[ \text{Yes} \ 2 \] \text{No} \\ 9 \] Unknown \] 23c. If yes, outcome of pregnancy \\ 1 \[ \text{Live birth} \ 2 \] \[ \text{Fetal death} \\ 3 \] \[ \text{Ectopic pregnancy} \\ 4 \[ \text{Pregnant at time of death} \\ 9 \] Unknown \\  23c. If yes, outcome of pregnancy \\ 1 \[ \text{Live birth} \ 2 \] \[ \text{Fetal death} \\ 3 \] \[ \text{Ctopic pregnancy} \\ 5 \[ \text{Other} \( \text{(specify)} \) \] \\ 9 \[ \text{Unknown} \]					23d. Date of delivery Month Day Year		
rds, P.		by							cco use contribute to the cause of death?	
al Records, The law requires to		Completed					24a. Was a autop perfor 1 Yes	sy prior t	autopsy findings available o completion of cause of es 2 No	
r VIII. ysician		To Be	25. Was case referred to medical examiner?  1 Yes 2 No  Hospital: 1	Inpatient 2 ER/0	Outpatient 3 DOA	Ythora	of Death (Check only or		Decity) HUSPICE	
on of		ion: T		e of Injury 28b. anth, Day Year)	Time of 28c. In Injury	jury at Vork?	28d. Describe h	ow injury occurred		
		Certification:	2 Accident investigation 3 Suicide 6 Could not be determined bui	ce of Injury - At home, ding, etc. (Specify)	farm, street, factory, office	Yes 2		street and Number or m, State)	Rural Route Number,	
e Hospita		Medical C	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number						29d. Date signed (Mo	nth, Day, Year)			
			30. Name and address of person who completed ca	use of death (Item 23a	) (Type, Print) 3	900 L	och Raver	n Boul	21218	
	Sta Registr		-0044	Registrar's Signature	A. park	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 Physician/ Sept Michael Joseph Streeks.Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 4403 Oakview Lane Bowie If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 217-42-8350 1 🗓 M 2 🗆 F May 14,1944 68 Washington D.C. Usual Residence of Dece 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Prince George's Bowie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4403 Oakview Ln. 20715 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Y
1 □ Yes 2 □ No Specify: 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates. Black, White, etc. \$ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 2 should be filed within 72... th and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) NASA Manager of Information Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Morris Streeks II Margaret Cecelia Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4403 Oakview Ln., Bowie, MD 20715 f Health attem 27 i Jacqueline M. Streeks/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page 1 Department of Important: If it any injury or o Bowie, MD Sacred Heart Cemetery 09/18/2012 21. Sign and Juneral 22. Name and Address of Facility Beall Funeral Home e Licensee 6512 NW Crain Hwy. Bowie, MD 20715 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Enter the dise Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause /Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 1 ☐ Yes 2 L 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred - Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 5 30. Name and address of person who completed 31. Date filed (Month, Day, Year) SEP 19 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER Physician/ STEPHENS CURTIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL THE JOHNS HOPKINS BALTIMORE CIT none 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 221-44-6450 50 Director 1 🏻 M 2 🗆 F Nov. 3, 1961 Delaware 27 is marked other than "naturai", or items 23a or 28a-f shov traumatic event, Tre Modical Exeminer must be notifiled at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Dorchester Federalsburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5220 Twelve Oak Drive 21632 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Army Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Property Book Officer DEARNG 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Stephens permit. Page 1 and 2 should be Department of Health and Men importent: If item 27 is marke any injury or other traumatic JoAnne Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5220 Twelve Oak Dr., Beverly Stephens / Spouse Federalsburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Hill Crest Cemetery 4 Donation 5 Other (Specify) 9/17/2012 Federalsburg, MD 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myartelic Physician/ Pancreetic Cancer disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 L Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death been signed be should be det Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of ours after death.

eral Director: After this certificate has I filled in by the funeral director, page 2. autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2

To the I

complete 29b. Signature and title of certifier 29c. License number RES-000 841 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21287 TAMNA WANGJAM 1800 ORLEANS STREET

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month ( Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Kris-Leigh Assisted Living <u>Severna Park</u> If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Apr. 26, 1927 Days Hours Min. **Director** 130-14-1214 1 【XM 2 □ F 85 New York or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Completed by Funeral Director MD Prince George's 1 Yes 2 X No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 13330 Idlewild Drive 20715 USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates. Navv 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) U.S.G.P.O. Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Thomas Smith Margaret Conovick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Thomas J. Smith 13508 Gresham Court, Bowie, MD 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady of the Fields 9/22/2012 Millersville, MD 22. Name and Address of Facility Beall Funeral Home Signature of 6512 NW Crain Hwy., Bowie, MD 20715 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Peath Part 1. Enter the dis shock, or heart fail Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day 9 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainle as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760 P.O. Division of Vital Records,

> 11 W State

address of person who completed cause of death (Item 23a) (Type, Print)

Signature and title of certifie

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5, per fh, g932 10-12-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ 2012 11:15A M Russell Errol Train Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Talbot Bozman 23470 Berry Road Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security 5**79-**52-( 5**79-60**-**Funeral** (Month, Day, Year) Days Hours 92 1 **X**M 2 □ F Director 1920 R.I. 6-4 – Usual Residence of Decedent 10d. Inside City Limits show 10b. County 10c. City, Town or Location 10a. State Director notified Martin 1 X Yes 2 No Hobe Sound 28a-f FL. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 must be 33455 Funeral 23a 114 Gomez Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12, Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ ō 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Me College (1-4 or 5+) Elementary/Secondary (0-12) Environmental Conservationist 5+ 12 Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, It once. Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Errol Cuthbert Brown 2 Charles Train II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2912 N Street N.W. Washington, D.C. C. Bowdain Train/ 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Delmar, DE. of Delmarva 9/19/12 4 ☐ Donation 5 ☐ Other (Specify) Crem. Hurley des Ostrowski Funeral Home Signature of Funeral Service Licenses m. Ostrowski p.o. Box 518 St. Michaels, MD. Losoph 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Conjestive Heart Failure Hears disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 10 Years Metral Regeritation if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been considered to the Funeral Director: After this certificate has been considered to the Funeral Director. Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown Cirrhosis 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Myelodyspleotic Syndromwe autopsy performed 1 Yes 2 No Bronchiectasis 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? X Other (Specify**Home** Summer Other: 4 Nursing Home 5 Residence 6 Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

TLS 11+VA

Registrar

DHMH 17 Rev 06-2011

State

3301 New Mexico Ave.

MUD

Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 heodore Li, e filed (Month, Day, Year) SEP 1 9 2012 14603

N. W.

9 / 18 / 2012

Suite 342

Washington.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Kris-Leigh Assisted Living Odenton If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours (Month, Day, Year) 579-42-5356 1 □ M 2 🕭 F Director Jan.20,1932 80 Washington, DC permit. Paga 1 and 2 should ba fliad within 72 hours aftar daath with tha Maryland Dapartment of Haalth and Martai Hygians. Importent: If item 27 is merked other than "netural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Anne Arundel Gambrills MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21054 2230 Dairy Farm Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. ڇ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Legal Secretary Law Firm 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Joseph Obert Ball Katherine Cullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2230 Dairy Farm Rd., Gambrills, MD 21054 Katherine Stroud timore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 09/18/2012 Suitland, MD 4 Donation 5 Qther (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Fundral Purple Licen 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung cancer disease or condition resulting in death) Medical Due for as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death cartificate be executed attanding physician and for usa as tha burial-transit Cause (Disease or Injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No ours aftar death. eral Director: Aftar this cartificata has bean signed by the a filled in by the funaral director, paga 2 should ba detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? Hospital: Other: 2 🗆 No 1 🗌 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di compistaly fillad li Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of)certifier MSKWAPK 00057465 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209-5203 2835 Smin AV NSKUKIPAKIEMO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 19 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend Item 14 per th 9932 10-4-12 vt
State of Maryland / Department of Feath and Mental Hygiene

For State Registrar amend #1 Per Phy G033 11/10/Settificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lucy Frances Werdebaugh Physician/ September 2012 3:48 P Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washington 211 Myers Street Hancock Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Country) Months -46 - 34761 □ M 2 🗓 F **Director** 82 Yrs 10/15/1929 Usual Residence of Deceden 10d. Inside City Limits 28a-f show 10b Count 10c. City, Town or Location 10a. State with the Maryland or items 23a or 28a-f shominer must be notified at Director 1 X Yes 2 No Washington Hancock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21750 USA 211 Myers Street permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black White etc. Armed Forces 1 Never Married 2 Married Yes 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify If Yes, Give 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant 8 Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William McKinley Fritzman, Sr. Anna Pearl Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 Myers Street Hancock, MD 21750 Darlene K.Mellott/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/02/2012 Berkeley Springs, WV Greenway Cemetery 22. Name and Address of Facility Signature of Funeral Service Licenses 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Part 1. Enter the disease or shock, or heart failure. List of Interval Between Onset and Death Immediate Cause (Final cardiovasci Physician/ du te disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as the t attending IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Month Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Ano 3 Probably 4 Unknown cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No Yes certific director, 25. Was case referred to medical examiner?

1 Yes 2 PNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify) မ ER/Outpatient 3 DOA 1 Inpatient 2 this funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After 1 Accident
2 Accident
3 Suicide 5 Pending 1 Yes 2 No after death Director: A d in by the f Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft To the Funeral Dir completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 135020 CRUP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harcock MD Tonoloway S 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Rudolph Ernest Wieser 2012 Sept 13 2:57a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 815 Courthouse Point Rd City Cecil <u>Chesapeake</u> Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 076-<u>22-6667</u> **Director** 1 💢 M 2 🗆 F 81 Yrs. 11/22/1930 NY 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 No MD Cecil Chesapeake City 10e. Street and Number ō 10g. Citizen of What Country? must be r Funeral 815 Courthouse Point Rd. 21915 USA 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No If Yes, Give Year or Dates. "natural", or item ledical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electronics Tech Military Ith and Mental Hygie 27 is marked other r traumatic event, the U.S. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Julius Wieser Marie Fuhrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Elissa Wieser/ Wife Ches. City,MD 21915 Courthouse Point Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/16/2012 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Foard Funeral R.T. Home, P.A. Rising Sun, MD Name and Address of Facility T.Foard Funeral Home, P.A. 318 George St. Chesapeake City MD 21915 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death with Metastasi Immediate Cause (Final Ph\_sician/ Medical resulting in death) Due to (or as a consequent e.d.) **Examiner** Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ō in the past 12 months? Month Day signed by the at d be detached fo Pregnant at time of death Other (specify) Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signated by the second of Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy performe performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No 5 Residence 6 Other (Specify မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical

8+IVA

State Registrar 29a. Certifier

(Check

Sacholoo).5 MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 9.14.2012.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S. SA-CHDEV MD, 126 A, E High SI, Elector MD 21924.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ George R. Wilson 9:42 P M September 2012 Medical Facility Name\_(if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Center Westminster Carroll 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 051-24-8921 82 **Director** 1**XX**M 2 □ F July 3, 1930 New York Usual Residence of Decedent 28a-f show 10d. Inside City Limits the Maryland Oa. State 10c. City, Town or Location notified at Director Maryland Anne Arundel Davidsonville 1 Yes 2XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò rms 23a or Funeral 3474 Constellation Drive 21035 U.S.A. items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status nit. Page 1 and 2 should be filed within 72 hours after dea nartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or iten injury or other traumatic event, the Medical Examiner. Armed Forces?

120 Yes 2 No
If Yes, Give 1947–53
Year or Dates. Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer Law Enforcement 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Roy Wilson Emily Moon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Wilson/wife 3474 Constellation Drive Davidsonville, MD 21035 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gardens 9/20/2012 | Davidsonville, MD 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final OKSTRUCTION Ph, sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, loading to in nediate cause. Enter Underlying Cause (Disease or injury but to for at a noneequence of: for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the a Hospital or Attending Physician: The law requires that the c24 hours after death.
Funeral Director: After this certificate has been signed by th P.O. art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed FIBRILLATION 24b. Were autopsy findings available 24a. Was an page 2 autopsy performed? prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Division of Vital completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 1 No 1 🗓 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural Natural iniury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Cheg To the l within 2 To the l only 29b. Sign e and title of certifier

DHMH 17 Rev 06-2011

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State Registrar WESTMINSTER MID

completed cause of death (Item

. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SEPT 2012 RICHARD F. WADE 23:20PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KLINE HOSPICE HOUSE MT. AIRY FREDERICK If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min. Hours Director 218-30-3460 1 **M** M 2 □ F 80 08/18/1932 MD 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director FREDERICK KNOXVILLE MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2713 WOLFE DRIVE 21758 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes. Give Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION TRUCK DRIVER Be 17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) CRAWFORD F. WADE EMMA NEWTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN WADE 2713 WOLFE DR., KNOXVILLE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STAUFFER CREMATORY 09/18/2012 FREDERICK, MD 21. Signature of Funeral Service (I)censee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 7 Months Physician/ disease or condition resulting in death) SMALL CELL LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the dornary the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) signed by the atter d be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Day 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown peen CORONARY ARTERY DISEASE Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy CHRONIC OBSTRUCTIVE PULMONARY DISEASE performed? Yes 2 № No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No မ Other: To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Gertifying Nurse Practitioner: Je the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: Je the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16428 09/17/2012 7% 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CASPER CLINE, 300 WEST NINTH STREET, FREDERICK, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20 | 2

			for State Registrar			tificate of L			Reg. No. 201	2 32011	
	Physicia		1. Decedent's Name (First, Middle, Last)  Mary Virginia Zimmerman				2. Date of De		3. Time of Death 10:06 a M		
Medic Examin			4a. Facility Name (if not institution, give street and number) 4b. (				r Location of Death		4c. County of D	eath	
Funeral			Carroll Hospital Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur				minster Tif Under 24 Hrs.	8. Date of Bir		Crroll  Birthplace (State or Foreign	
	rector		216-66-1491	I □ M 2 <b>X</b> F 54		Months Days	Hours Min.	Nov 2	7 1957 Pe	ennsylvania	
land	show	Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								
e Mary	r 28a-1 notifie		Maryland Carroll Taneytown  10e. Street and Number 10f. Zip Code 10g. Citizen of What Indicates the control of					10a Citizen of What	1 🗆 Yes 2 🔊 No		
with th	th and Marial Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	eral	3995 Sells Mill :	Road		101. Zip 00de	21787		-	SA	
<b>)036</b> irs after deatt		þ	11. Marital Status 1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	- 1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🕱 No		pecify Yes or No- o Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. white	
<b>15-(</b>	n "nati Nedica	Completed	15. Decedent's (Specify only highest g	rade completed)	(Give	dent's Usual Occup kind of work done o O NOT use retired)	during most of wor	king	16b. Kind of Busine	ss Industry	
212 within giene.	her tha t, the M		Elementary/Seconday (0-12)	College (1-4 or 5+)		outer Pro			Book Wi	nolesaler 	
land be filec	rked ot tic even	To Be	17. Father's Name (First, Middle, Last) Paul Humbert					ne (First, Middle, yn Baumo	Maiden Surname) <b>Jardner</b>		
e, Mary and 2 should Health and M	item 27 is marke other traumatic		19a. Informant's Name/Relationship ( David Zimmerman,						r, City or Town, State,		
Baltimore, Maryland 21215-0036  sernit. Page 1 and 2 should be filed within 72 hours after  Department of Health and Mental Hygiene.	Important: If iter any injury or oth once,		20a. Method of Disposition  1 Surial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	emetery, cren	sition (Name of natory or other plac rch Cemet		Date 3/2012	20c. Location - City  Tyrone,		
Balt permit. Departr	any in		21. Signature of Funeral Service Licen	see					ooraw Fune town, MD 2		
ீசிருள்			23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  The Complete Comp								
Me	edical miner		resulting in death)  a. Due to (or as a consequence of):								
77	=	iner	Sequentially list conditions, if any, leading to firm leulate cause. Enter Underlying								
xecuted	ng physician and as the burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last    Due to (or as a consequence of):								
<b>8 / 6U</b> Ifficate be executed	he buri	Medical	d								
<b>BOX 08 /</b> e death certification the attending or	the attending p	<b>5</b> I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnar 1   Live Birth 2  Fetal 4   Pregnant at time of d 9  Unknown	death 3 [	Ectopic pregnand Other (specify)	by		23d. Date of Month	delivery Day Year	
s that the	igned by be detac	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown								
ords require	should	Completed		MR II DIN	, BETEJ	meu.	, the	1 L 24a. Was		autopsy findings available	
Kecords, The law requires	ate has page 2 :	Somo		sesin	JC (C-			autor perfo	osy prior t ermed2 death	o completion of cause of	
VITAI iysician:	rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Othe	ace of Death (Chec	ck only one)			
on or value of value	24 hours after death. Funeral Director: After the ted filled in by the funera	cate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day, Year)	EH/Outpatien 28b. Time of injury	outpatient 3 □ DOA   4 □ Nursing Home 5 □ Re Time of   28c. Injury at   28d. Describe			esidence 6 U Other (Specify) e how injury occurred		
DIVISION tal or Attendir rs after death.		l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)			treet, factory, office 28f. Location		28f. Location (S City or Tow	(Street and Number or Rural Route Number, own, State)		
L ne Hospit in 24 hour en Funers		Medical	(Check 2   Medical Exam	sician: To the best of my knowle iner: On the basis of examination se Practioner: To the best of my	and/or invest	igation, in my opinic	on, death occurred a	at the time, date a	ind place, and due to th	e cause(s) and manner stated.	
To t			29b. Signature and title of certifier	M - ~	~>	29c. License	number		29d. Date signed (Mo.	nth, Day, Year) 10 - 12	
HUN	ا ما		30. Name and address of person who		23a) (Type, P	rint) Freder	cý st.	TA	SENTOW	, MD 21787	
	Stat egistra	٠ ا	31. Date filed (Month, Day, Year) SFP 1 1 20	32. Registrar's Signatu	re 4	N.I					

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	State of Maryland / Department of Health and Mental Hygiene 2012 32012									
		-	Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of De	eatn	2. Date of De	Reg. No.	3. Time of Death		
	Physicia Medic		Leola Virginia Abdullah SIPTEMBER 30 2012 / 3							
	Examin	er	4a. Facility Name (if not institution, give street and number) Balto./ Washington Med. Cente	4b. City, Town, or Lo	ocation of Death  BUR	NIE	4c. County	YNE ARUNDEL		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthde	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 01/08	y, Year)	9. Birthplace (State or Foreign Country) Maryland		
pue	show	or	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or	Location	<u> </u>	l		10d. Inside City Limits		
Maryl	28a-f	Director		eren				1 🗌 Yes 2 🛣No		
vith the	23a or st be n	eral D	10e. Street and Number 7821 Statesman St.	10f. Zip Code 21144	4		10g. Citizen of U.S.			
death v	items ier mu	Funeral		Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No- Rican, etc.)	14. Rac	ce - American Indian,		
336 after 6	al", or Examir	To Be Completed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🙀 No		, , ,	Specify			
<b>21215-0036</b> within 72 hours after	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inporpartie file m Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		15. Decedent's Education 16a. De	ecedent's Usual Occupation	ion ring most of worki	ina	16b. Kind of B	Business/Industry		
2121 /ithin 7			Elementary/Secondary (0-12) College (1-4 or 5+)	a. DO NOT use retired) Assistant			Self E	Employed		
nd 2			17. Father's Name (First, Middle, Last)		8. Mother's Name	e (First, Middle,				
ryla be			Attus Kane Sr.		Amy Sc					
Ma d 2 sho				ailing Address (Street and 21 Statesm						
Baltimore, Maryland permit. Page 1 and 2 should be filed	ent of He nt: If item ry or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)	sposition (Name of crematory or other place) em. Park	10/0	8/12		- City or Town, State		
Baltil permit. F	Departm Importai any injui once,		21. Signature of Funeral Service Licensee	2 <b>₹™S€®h</b> ddr∰s.	of F <b>B</b> ibown	Jr. F	uneral Baltimo	Home PA ore, MD 21217		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		-			Approximate Interval Between		
	sician/			CCARC	INOM	A		Onset and Death		
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a.   METASTATIC CARCINOMA  Onset and Death  TUFEKS  Due to (or as a consequence of):  ACUTE RENAL FAILURE  3 WEEKS							
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executed	ian and irial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):	2 POUP	ONA	Cy E.	1-11362			
	ysician ysician		d. MULTIF	LE MY	IELD.	MA		7 WEEKS		
6876 ertificat	ding ph se as th	/Mec	17 FEMALE: 23c. If yes, outcome of pregnancy							
Division of Vital Records, P.O. Box 68760 talor Attending Physician: The law requires that the death certificate by	e attended for us	Completed by Physicia	in the past 12 months?  1 Ves 2 No  1 Pregnant at time of death	3				ate of delivery onth Day Year		
o. Hat the	d by th letache		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause giver	n in Part I.	23e Did to	obacco use cont	tribute to the cause of death?		
S, P	within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but							3 ☑ Probably 4 ☐ Unknown		
cord aw requ						24a. Was		Were autopsy findings available prior to completion of cause of		
Re I						1 🗌 Yes	ormed? 2 No	death? 1  Yes 2 No		
<b>Vita</b> /siciar	s certii directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🔀 No  Hospital:  1 📆 Inpatient 2 ☐ ER/Outpa	Other:	e of Death (Check		dence 6 \( \text{Oth}	ner (Specify)		
of Ing Phy	fter thi		27. Manner of Death  1 Manner of Death  2 Manner of							
Sion	ctor; A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be							
Divi	irs after al Dire		4 Homicide determined 20e. Place of Injury - At norme, farm, building, etc. (Specify)			City or Tow				
he Hospi	within 24 hou  To the Funer  completely fill	Medical	29a. Certifier  (Check 2 Medical Examiner: On the best of my knowledge, deal only one)  2 Certifying Nurse Practitioner: To the best of my knowledge.	vestigation, in my opinion,	death occurred at	the time, date a	and place, and du	ue to the cause(s) and manner stated.		
Tot :			29b. Signature and title of certifier  Samue Jain MD	29c. License nu				ed (Month, Day, Year)  MRER 30 2012		
	30		30. Name and address of person who completed cause of death (Item 23a) (Typ SAMIR JAIN 30/	HOSPIT.	AL DR	IVE G	UEN, BU	RNIE, MD 21061		
F	Stat Registra	_	30. Name and address of person who completed cause of death (Item 23a) (Type S A / N 30 / 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Nes						
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State of Maryland / Department of Health and Mental Hygiene 20 | 2 32013 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Day 28, Margaret **Illis** Anderson 6:15 p.M September 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Home Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 139-18-4988 Usual Residence of Decedent 1 M 2 TXF Yrs. Nov. 20, 1920 New Jersev iral", or items 23a or 28a-f show Extrininer must be notified at 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery 1 🗆 Yes 2 🔀 No Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15100 Interlachen Dr. #501 Apt 507 20906 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 A No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 all Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the the International Affairs Consultant Be 17. Father's Name (First, Middle, Last) Should be file ond Mantal H is marked of 18. Mother's Name (First, Middle, Maiden Surname) Louis Illis Barbara Novakovits 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15100 Interlachen Dr. #301 Silver Spring, MD 20906 Page 1 and 2 sh mant of Health er tant: if item 27 is Edwin Y. Brown (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Oct Date 5. 20c. Location - City or Town, State permit. Page 1 Departmant of Important: If it any injury or o cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 X Cremation 3 Removal from State 2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician Onset and Death End Stage Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should ba detached for use as tha burial-transit or Attending Physician: The law raquiras that tha death cartificate ba axacuted lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ CHRONIC KIDNEY DISEASE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificata Yes 2XXNo 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: XX No Other: 4XX Nursing Home 5 Residence 6 Other (Specify) 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours aftar death.

To the Funeral Director: After this completely filled in by the funaral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred XIX Natural 5 Pending injury 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69148 v. v. OCTOBER 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 MOLECULAR DR. #205, ROCKVILLE, MD 20852 THERESA A. MATAS, M.D., 31. Date filed (Month, Day, Year) 62. Registrar's Signature State OCT 0 5 2012 back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 2012 <u>Jonathan Paul Albers</u> Medical September 30. 22:05 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Suburban Hospital</u> <u>Bethesda</u> Montgomery **Funeral** If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Months Days Hours Min. (Month, Day, Year) **Director** 215-02-3561 1 🕅 M 2 🗆 F Yrs Usual Residence of Decede February 15,1968 Maryland ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Directo Maryland Montgomery 1 Yes 2 X No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 55<u>17 Huntington Parkway</u> 20814 "natural", or items edical Examiner mu <u>United States</u> 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No , or Black, White, etc. 1 X Never Married 2 - Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry rould be filed within 72 and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) United States 12 Computer Engineer <u>Government</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Wayne Albers Frances Beeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a <u>Frances B. Albers/ Mother</u> or other 5517 Huntington Parkway, Bethesda, Maryland 20814 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Methesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
M00198 Bethesda, Maryland 20814-3501

ne death. Do not enter the mode of dving such as a contract of the such a October 8, 2012 21. Signatury of pneral prvice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician theroscient disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner que itially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Box 23d. Date of delivery 3 Ectopic pregnancy that the death in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Dav Year 5 Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵. Completed by 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examine?
1 Yes 2 No ည 1 🗌 Inpatient 2 📮 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide 24 hours after death e Funeral Director; A bletely filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie D66896 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 <u>Matthew Leonard,</u> M.D.State 31. Date filed (Month, Day, Year) 32. Registrar's Sign OCT 0 5 2012 Registrar DHMH 17 Rev 06-2011

Toncollan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ October 3, Day 2012 Bertha 1:34 P M Aaron Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heartfields at Frederick Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Months Min (Month, Day, Year) Director 003-16-4155 1 🗆 M 2 ី F 86 Yrs May 8, 1926 New Hampshire ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Frederick 1 X Yes 2 No Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 232 Cobble Way 21793 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Jacob Sarkisian Satenig Bagdorian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Keckler/Daughter 232 Cobble Way, Walkersville, Maryland Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important: If its any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) Entombment October 2012 Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 M01173 23a. Part 1. Enter the disease, or or implication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Kidney Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed use (Disease or injury sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 🗍 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 🗓 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) Asst. Liv. 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 D Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral Completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 191619 MA October 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Lerner, M.D. 63 Thomas Johnson Drive, Suite E, Frederick, Maryland 21702 31. Date filed (Month Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 3 Day 2012 Year 1:10 Esther Nelly Garcia De Alurralde Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6204 Brookside Drive Chevy Chase Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) Director 565-85-7863 1 □ M 2 K F 85 August 21, 1927 Argentina Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funera 6204 Brookside Drive 20815 Argentina within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 🕅 Yes 2 🗆 No Specify: Argentinian 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Surgical Nurse Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Inocencio Garcia Victorina Rosalia Diez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6200 Brookside Drive, Chevy Chase, Maryland 20815 Gabriela Smith / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 e
Department of H
Important: If ite
any Injury or ot 20c. Location - City or Town, State October 9. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment Rock Creek Cemetery 2012 Washington, D.C. Signature of Funeral Service Ligensee ROBERT A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Year Immediate Cause (Final Physician/ Metastatic Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit Cause (Disease of injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🗓 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) ဍ

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. After this certificate To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fur

examiner? 1 🗌 Yes 2 🔀 No Other: 4 Nursing Home 5 🖾 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

D14107

October 4, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

Bryan J. Arling, 2440 M Street, NW #817, Washington, D.C. 20037 M.D.

State Registrar

Certificate:

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Detuh 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death topital dorUSTO Cimens 8. Date of Birth (Month, Day, Year) Funeral Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Days Months Hours 213-20-3900 **Director** 1 □ M XIXF 87 Yrs. May 12, 1925 Maryland il Hygiene. I other then "naturel", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2📉 No Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Harden Ave. 21117 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes XX No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🗶 💆 No Specify: Specify: White XX Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Worker of Health and Mental Hygie If item 27 Is marked other in other traumatic event, # Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert Marquess Ruth Marquess permit. Page 1 end 2 should be Depertment of Health and Men Important: If item 27 is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harden Ave. Owings Mills, MD 21117 Darrel D. Allen / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Faiths
Crematory & Chapel 20a. Method of Disposition
1 ☐ Burial X2X Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Dry & Chapel: 10/10/12 | Manchester, MD 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 10/10/12 21. Signature of Juneral Service Licensee 11605 Reisterstown Rd. Owings Mills MD2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to or as consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day signed by the aid be detached for g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: မ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh g932 10-10-12 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 9:30 a M SEPTEMBER 26,2012 JOHN BOURKE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE 6228 EVERALL AVENUE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 217-78-5417
Usual Residence of Decedent 1 XM 2 🗆 F AUGUST 4,1956 56 Maryland Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other treumatic event, the Macical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 ☐ No BALTIMORE N/A MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6228 EVERALL AVENUE 21206 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 2 1 Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 👿 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) IINTON 8TH CARPENTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 MARY HERMAN NORMAN BOURKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER 213 ARMSTRONG LANE PASADENA, MD. 21122 NORMA DOWNS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
eny Injury or ott 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-1-2012 GLEN BURNIE, MD. ATLANTIC CREMATORY 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 21. Signature of Funeral Service Dicensee NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition heart (ongestive Physician/ VE GO Medical resulting in death) Due to (or as a consequence of): Examiner chi sease y earl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by 6 ballation histon Stroko 1 🗹 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 2 🗹 No To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director. After this certificate I completely filled in by the funeral director, pag 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred iniury 5 Pending 1 V Natural 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00065145 MI Tu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21230 Raven Blud hoch UlGa Luiye MO

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 25, MARD 7:04 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death ial Security Number last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Age (Ir Hours Min. (Month, Day, Year) 383-42-0538 Director 68 1 🔀 M 2 🗆 F Yrs. MT 2/13/44 show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director PA Lancaster 28a-f Lancaster 1 XYes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3191 Cottonwood Ct 17601 USA items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 01 Black, White, etc. þ 1 Never Married 2 Married Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" Specify. White Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Parts Analyst Tractor 12 Be f and 2 should be of Health and Mental Hy tem 27 is marked of matic eve ather's Name *(First, Middle, Last)* **Charles E.** Br 18. Mother's Name (First, Middle, Maiden Surname)

Leona Secord Broegman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3191 Cottonwood Ct, Lancaster PA 17601 Patricia J. Picciani /Daughter Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 s 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Cem 10/1/12 Clarkston, MI lature of Funeral Service Licensee Victor Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Avenue Baltimore MD 11 1501 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ asystole disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** morrhage Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Exami disseminated intravascular sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical O. Box 68760 SERSIS attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 MNo 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed certificate 2 🗆 No 1 Tes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 28d. Describe how injury occurred **V**Natural injury 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific RES-000 SEPTEMBER 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIEANS St, BALTIMORE, MD 21287 Haitham Hhmed, MD

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Burroughs 1630 Mattie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good samaritan Hospital Baltimore, MD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours 250.66.5924 Director 1 □ M 2 🔀 F SC 1939 OI 01 Usual Residence of Decedent 10d. Inside City Limits 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt: If item 27 Is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 27 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Columbia MD 1 Yes 2 No Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7070 Winter Rose Path 21045 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Falcone 12th grade Domestic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Florence Horace, Burroughs 19a. Informant's Name/Relationship (*Type, Print*) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 319 Walters Avenue Baltimore MD 21239 Jacque ly Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pikesville, MD 1011/2012 Druid Bidge 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 1 Road Randallstown MD 21/33 8728 Libert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final right middle cerebral artery ischemic strake Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner tallure respiratory Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of. Hospital or Attending Physician: The law requires that the death certificate be executed ser-sis After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Pregnant at time of death 9 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diabetes mellitus, coronary artery disease, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Kidney disease autopsy performed?/ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hin 24 hours after death. the Funeral Director: After this mpletely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESCOO 2012 10 101 M.D.

State Registrar Baltimore, MD 21239

Lock Raiven Blvd.

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tifficial Fiftingia 56 31. Date filed (Month, Day, Year) OCT 0 4 201

5'60i

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32021 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frederick Gabriel Buchness October 4 2012 ar 6:32 A. M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 600 Oak Hill Road Catonsville Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) June 16,1933 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🙀 M 2 🗆 F Director 79 213-32-2855 Maryland June Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 600 Oak Hill Road 21228 USA item 21 is marked other than "natural", or items other traumatic event, the Medical Examiner mu should be filed within 72 hours after death and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 4+ Personnel Officer State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John A. Buchness Catharine Horn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mary Ruth Buchness Wife 600 Oak Hill Road; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State New Cathedral Cemetery 10/8/2012 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) Tunerard Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee Mp1234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC 5 months disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of Box 68760 CL that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician are completed filled in by the funeral director, page 2 should be detached for use as the burial-inresulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Pregnant at time of death Month 1 Yes 2 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an autopsy performed Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date, signed (Month, Day, Year) D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD 1. Date filed (Month, Day, Year) State OCT 0 5 Registrar

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ eodor Detober Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death 164 land timore 8. Date of Birth If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Hours Min (Month, Day, Year, Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No with the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 and Mental Hygiene. is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Black 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 764 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau 140 MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-9-2012 . Signature of Funeral Service Licensee 22. Name and Address of Facility paltimore 2/202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? been signed by the a should be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? after death.

Director: After this certificate 1 Yes 2 No Division of Vital completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature d title of certifi

State Registrar 31. Dave filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Month **Physician** 7:45 PM villiam october /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and r. 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Johns Hopkins Bayview Medical Center **Baltimore** N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 1 X M 2 □ F Months Days 70 216-40-1986 Director Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Md. Baltimore Dundalk Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or with 624 Aldworth Rd. 21222 LISA Funeral 2 should be filed within 72 hours after death and Mental Hygiene.

Is marked other than "natural", or items 23 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) Baltimore City Waste Water Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be 1 Benard J. Boehmlein Mary Ann Zygmont 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Important: If item 27 Is any Injury or other trau Geneva Boehmlein 624 Aldworth Rd. Dundalk Md. 21222 wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Baltimore 4 Donation 5 Other (Specify)

21. Signature of eral Service of the Bayview Crematory Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmorary **Physician** CHRONIC obstruct resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts.) Examine Duri, to for an a connection me of: requires that the death certificate be executed that initiated events burial-trai and resulting in death) Last Due to (or as a consequence of) nding physician are use as the buria Box 68760. Physician/Medical attending IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 □ No P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 Encephalopethy 2 No 3 Probably 1 Tyes Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed? 2 2 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 PNo 1 Inpatient 2 ER/Outpatient 3 🗆 DOA ρ after death. Director: After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury or Attending 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Hill rerence

OCT 0 5 2012

29b. Signature and title of certifier

31. Date filed (Mo.

29c. License number RES-000 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

4940 Eastern Avenue, Baltimore, MD, 21224

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 2012 Baer James Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) **Director** 215-48-3946 1 X M 2 □ F 56 Oct. 4, 1955 New York Usual Residence of Deced 28a-f shov 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits be notified Laurel MD Prince George's 1 Tes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a 15508 Park Hall Court 20707 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force ö Completed by Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural" 3 Divorced 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College\_(1-4 or 5+) the Computer Technician Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edith Robert Baer Furst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Victoria A. Borland / Wife 15508 Park Hall Ct., Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State per nit. Page 1 a Der artment of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 10/04/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Ligensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Cardiopulmonary Physician/ disease or condition resulting in death) Medical Examiner Myocardial Infarction 2 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (r as a consequence of): Cause (Disease or injury anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has filled in by the funeral director, page 2 autopsy performed Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 LER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 P.O. Records, **Division of Vital** within 24 hours after death. To the Funeral Director: After To the Hospital or Attending

State Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

determined

Laurel Regional Hospital, Emergency

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a. Certifier

29b. Signature and title of certifier

Noah Gutierrez

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

072380

7300 Van Dusen Road

29d. Date signed (Month, Day, Year)

Laurel, MD

10/2/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e State SHMGP, 22nd 9669420162nt Un Health and Mental Hygiene \_ State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ ROBERT BARKSDALE 2012 0250 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY ADVENTIST WASHINGTON HOSPITAL **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours 226-24-6031 9 /29 / 1923 **Director** 89 Yrs. VÍRGINIA 1 X M 2 □ F Usual Residence of Decedent al Hygiene. I other then "natural", or items 23a or 28a-f show vent, the Medical Everriner must be rediffed at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 ☐ No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Funeral 20019 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ۾ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. BLACK Completed 3X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired TRUCK DRIVER Elementary/Secondary (0-12) 12th College (1-4 or 5+) PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mental His marked o permit. Page 1 end 2 should be fil.
Department of Heelth end Mental
Importent: If Item 27 is marked of
eny injury or other traumetic eve ROBERT BARKSDALE BESSIE ANN DENNIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE LYNCH/DAUGHTER FOOTE ST NE #301 WASHINGTON. Baltimore, D.C.20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BELTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee CAPITOL MORTUARY 20002 425 MARYLAND AVE NE WASH or complications that cause the death. Of other the mode of dying, such as cardiac or respiratory arrest, it only one cause on each line. 23a. P. 1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Linguistry Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director. After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the humant-remaint. Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown <u>6</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes 2 X No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 12 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Division 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number address of person whe completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 06-2011

Registrar

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per Phy G932 10/05/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)

Allan Crawf 2. Date of Death Physician/ SeMonth Crawford 4:56 PM Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore Baltimore City Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 212 74 2041 Months Days Hours Min **Director** 59 1 X M 2 🗆 F March 26 1953 Yrs Baltimore, Maryland Usual Residence of Decedent 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Dutrow Court Apt. 1C 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 X Never Married 2 Married 1 ☐ Yes ※X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Francis H. Crawford Philomena E. Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret H. Jones (Cousin) 1716 Aberdeen Road Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory Inc Sept. 26 2012 re of Funeral Service Licensee 22. Name and Address of Facility Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between et and Death Immediate Cause (Final Ph\_sician/ disease or condition ) Medical resulting in death) Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physic an: The law equires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Medical Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

A Pregnant at time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director: Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Gertifying Nurse Practitionen To the best of my knowle 29b. Signature and title of certifie 29c. License number eted cause of death (Item 23a) (Type, Print) vesc 100 Date filed (Month, Day, Yest) State OCT O 5 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 29 2012 hirley 6:50 PM onnor Medical en 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner 2122 Walbrook Ave. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Days 219-32-8044 Director 1 M 2 F Yrs 76 06/18/1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or then "natural", or items 23a or 28a-f sho 10d. Inside City Limits Directo N/A Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2122 Walbrook Ave. 21217 U.S.A. Page 1 and 2 should be filed within 72 hours after death v ment of Heelth end Mental Hygiene. ant: If item 27 is marked other then "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Grade Housewife ith end Mental Hygie
27 Is marked other
r traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မှ Arthur Rivers Jeanette Pollard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2116 Walbrook Ave., Baltimore, MD 21217 Denise Simmons(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 Removal from State ò Department Important: If any Injury or once. on-site Crematory 4 ☐ Donation 5 ☐ Other (Specify) Himore 140 10/08/12 21. Signature of Funeral Service Licenses 22. JOSEPHORE FOR DETOWN Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ brovascu disease or condition ere Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): for use as the burial-transit Due to (or as a consequence of): ŵ resulting in death) Last the attending physician Physiclan/Medical or Attending Physician: The law requires that the death certificate be of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 W No
9 Unknown 3 Ectopic pregnancy Month Pregnant at time of death Day 5 Other (specify) Year been signed by the a should be detached g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes autopsy within 24 hours efter deeth.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag ☐ Yes 2 ☐ No 1 Yes 2 🗆 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Division 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) the Hospital Medical 29a Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 005333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Aviation Seay 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

OCT 0 5

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32028 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ C Month Anna Mae Cameron 245 am opember Medical 4a. Facility Name (if not institutjon, give street and number Examiner 4c. County of Death N/A more 8. Date of Birth If Under 1 Year If Under 24 Hrs. **Funeral** (In yrs. last birthday, 9. Birthplace (State or Foreign 1 □ M 2X F 212-58-5613 Hours 0642611949 63 Yrs Marwland **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No 10e Street and Number o 10f. Zip Code 10q. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be ready injury or other traumatic event, the Medical Examiner must be ready. Funeral 11 W. 20th St. 21218 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Frederick Villa (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Nursing Home Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lee Grant Cameron Marie Cureton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 5904 Charnwood Rd., Catonsville, MD D 21228 Latania Cameron (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from King Mem. Park 10/05/12 | Baltimore, 4 Donation 5 Other (Specify) Sign Tre of Funeral Service Licer se 27 to sephdorHs oBrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MDPart 1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ meumona disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury -transit The law requires that the death certificate be executed and that initiated events resulting in death) Last burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Be Completed by Asthma, Cerebrovasculae Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should spertension, Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work 2 Accident 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in manufacture death. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier M.D. Ph.D. 09/30/2012 person who completed cause of death (Item 23a), (Type, Print) lary/and

Registrar

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 Anita Resnick Cunitz Medical 2012 8:45 рΜ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Oeath 4c. County of Oeath Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Oate of Birth Birthplace (State or Foreign Country) Months Days Hours Min. (Month, Day, Year) 039-24-1840 Director 74 1 M 2 1 F Yrs. 9-26-1940 Rhode Island nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland sertment of Health and Mental Hygiene. ortent: If item 27 is marked other then "natural", or itema 23s or 28s-1 show injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5205 Trailway Drive 20853 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 Never Married 2 Married Black, White, etc. Š Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Oivorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Psychology Consulting Elementary/Secondary (0-12) College (1-4 or 5+) Research Psychologist Human Factors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Israel Resnick Mollie Bornstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Belstock - Daughter 2035 N. Commerce Street, Milwaukee, Wisconsin 53212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) National Crematory 10-6-2012 Falls Church, Virginia 21. Signature of Funeral Service Licensee / Brian Deibler 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Lucian 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Myocardial Medical Oue to (or as a consequence of): Examiner Chronic obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Hospital or Attanding Physician: The law requires that the death cartificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Oate of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by this cartificata has baan signal director, paga 2 should ! 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA s aftar daath.
I Director: Aftar this id in by the funaral di Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, To the Hospital or within 24 hours aft To the Funaral Dir complataly filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in rry opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier D0064413 October 4, 2012 5V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith 9901 Cotr Dr Rockville MD mD medical 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

10/3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Physician/ -3:45 P M Charlotte Eugenia Case Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore Manor Care @ Rossville 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Ye Sept. 12 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. 1935 Washington, DC Days Hours 1 🗆 M 2 🕮 Months 557-48-4670 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County notified at Director 1 Yes 2 No Bel Air Harford Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ö ms 23a or 21014 Funeral filed within 72 hours after death with USA 101 Williams Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🙀 No Yes, Give ō 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White "natural" Completed 3 Divorced 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med U.S. Government College (1-4 or 5+) Elementary/Seconday (0-12) Secretary 18. Mother's Name (First, Middle, Maiden Surname) Be 17 Father's Name (First, Middle, Last) Louise (nmn) Major မ Page 1 and 2 should be Norris Robert Friel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 101 Williams Street, Bel Air, Maryland 21014 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Doug Case / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Bel Air, Maryland Rose Hill Svcs, LLC 10-3-2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause \_\_\_\_\_ch Interval Between Onset and Death Immediate Cause (Final ire Physician/ disease or condition resulting in death) Medical Due to (or all Examiner Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be to the hours after death.

Funeral Director: After this certificate has been signed by the attending physicial. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FFMALE 23d. Date of delivery 23b. Was decedent pregnant Year Month Day in the past 12 months? 21/10 Yes g Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner eath 28c. Injury at Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within 2 To the 29b. Signature ar who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32031 State of Maryland / Department of Health and Mental Hygiene ( 1 \_ State Certificate of Death Registrar I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PM 2012 29 1ctober Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Baltimore Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 218-26-6080 Director 1 M 2 X F 8 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD 1 X Yes 2 ☐ No ō Of. Zip Code 10g. Citizen of What Country? be Funeral 23a ILSA must h Kenwood 21205 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ed other than "natural", or ite event, the Medical Examiner Armed Forces or ð 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than ' traumatic event, <u>the Me</u> condary (0-12) College (1-4 or 5+) 🗛 Home tomenaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ည hompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) jarrison Forest 12-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph\_sician/ mtracronia Medical resulting in death) Examiner uper tension Sequentially list conditions, it any leading to it is cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Diabetes and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Yes 2 No should be detached the g Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has the funeral director, page 2 autopsy perform Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 X Yes 2 No Certificate: To 1 🗓 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100 october ss of person who completed cause of death (Item 23a) (Type, Print) Baltimore Benjamin 1800 Orleans 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 0 5 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month At A Physician/ havles COOK 08:05AM 2012 otembe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 213-72-9360 **Director** 1 X M 2 □ F 50 09/13/1962 Maryland Usual Residence of Decede 28a-f show 10a. State 10b County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Xyes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 2608 Huntingdon Avenue 21211 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White Specify: Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Joseph Cook, Sr. Frances Gertrude Hook permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Joseph Cook, Jr. 2608 Huntingdon Avenue Baltimore, Maryland 21214 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Cramareri Ofmatory or other place) 20c. Location - City or Town, State Hanover, Maryland 10-2-12 4 Donation 5 Other (Specify) Center of Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. any inj michael 1. Margue 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ HIV disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** end stay liver diseas Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit nd stage renal disease that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 又Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and place, and place, and due to the cause (s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nature and title of certifier 29c. License number September 20, 2012 sica 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21218-Jessica 201 EUniversit CKWay

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 09/26/2012 Helga Conley-Shelton 1:15 a M Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Glen Burnie Glen Burnie Health & Rehab Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 03/01/1950 1 🗆 M 2 💢 F Germany 218-06-6813 62 Director Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County Director Glen Burnie Anne Arundel 1 Tes 2 No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 Germany Completed by Funeral 105 Southfield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces ☐ Yes 2 X No 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 3 Widowed 4 X Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other than College (1-4 or 5+) Health Elementary/Seconday (0-12) Certified Nursing Asst the 18. Mother's Name (First, Middle, Maiden Surname) Erika Rosa Baaden Be 17. Father's Name (First, Middle, Last) Unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 105 Southfield Road Glen Burnie MD 21060 son Sven Steinberg Department of Health as Important: If item 27 is any injury or other trauonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 9/28/12 Glen Burnie MD Atlantic Crem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv Ameral Service Licenses ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Betyeen Onset and beath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnapt 3 Ectopic pregnancy Month Day Year in the past 12 months 5 Other (specify) Pregnant at time of death g Unknown 23e. Did tobacco-use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Des 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cade of death? 24a. Was an autopsy performed Yes 2 1 1 Tes 26. Place of Death To Be 25. Was case referred to medical examiner? Other: ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of Death Certificate: 27. Manner atural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours at To the Funeral D completed filled in Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and title of certifie State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nicolina Month 9/26 C. Dicello Physician/ 8:45pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore 9. Birthplace (State or Foreign **Funeral** Social Security Number 178–20–6025 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Director 1 M 2 X 98 11/5/13 Usual Residence of Decedent show 10h Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director or 28a-f sl MD Baltimore Timonium 1 Yes XX No Street and Number 25 Westminster Bridge Way ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21093 USA ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc or. Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. 1 Yes If Yes, Give 2 XX0 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White **XX**Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Pipe Production Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SEPTEMBER ဂ္ Pasquale Costello Louise Destrola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
25 Westminster Bridge Way, Timonium MD 21093 19a. Informant's Name/Relationship (Type, Print)
John Dicello / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Place of Disposition (varies of cemetery, crematory or other place)

St. Bernard Cemetery 1 🗆 Burial 2 🗆 Cremation 3 🔀 Removal from State St. 10/2/12 Bradford, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Victor P. 22 Name and Address of Facility Charles L. Stevens Funeral Home, 1 1501 E. Fort Avenue, Baltimore MD 1000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): NICOLINA DICELLODivision of Vital Records, P.O. Box 68760  $ot \sim$ To the Hospital or Attending Physician: The law requires that the death certificate be ex physician Physician/Medical the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 9-27-2012-Tupe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 2300 DULANEY VALLEY ROAD JUSTINE PREIS, TIMONIUM MD 32. Registraris Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5,30 Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** HIMOLO Maine If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign curity Number 7. Age (In yrs. last birthday, **Funeral** Country) (3-A 95 Hours Min. (Month, Day, Year) 1 - M 2 1 F -921 Yrs Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 Xes 2 No more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygient and marked 23a ant. If item 27 is marked other than "natural", or items 23a uny or other traumatic event, the Medical Examiner must bury or other traumatic event, the Medical Examiner must but or other traumatic event, the Medical Examiner must but on the properties of th Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWI Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SIMIMOUS 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Baltinion, Department of Important: If any injury or 10 podlawa 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service saltimore iki 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARD ARRESI Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last ENTENSION Physician/Medical IF FEMALE ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown ESTEROLEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 Yes 2 No Yes 2 No certificate director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 21 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce

State Registrar

DHMH 17 Rev 7/2009

rtegistrai

30. Name and address of person who completed cause of death (Item?

WORE

AMBACHEN

31. Date filed (Month, Day, Year)

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32 Registrar's Signatu

1940 W.BATIMORE

BALTO ULG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month October 2 a.™ Jorge Claudio de la Puente 6:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 3, 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min Director 1929 063-48-9396 83 Peru Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MDMontgomery Rockville 1 Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Rd. #2198-B 20852 Peru items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican. etc. Black, White, etc. 0 1XXNever Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White "natural", 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ° Elementary/Seconday (0-12) College (1-4 or 5+) Manager Agriculture 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ismael Julian de la Puente Maria Felicia Noriega 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 (nephew) Mariano de la Puente 3330 Leisure World Blvd. #521 Silver Spring, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct Date 4. permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 2012 Beltsville, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph si i n Perion dia tamponad disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Preumonia Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury cerebrovascular accident or Attending Physician: The law requires that the death certificate be executed bunial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical attending physic for use as the b IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 1 Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perfor certificate 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 410 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No within 24 hours after death To the Funeral Director: A Investigation 6 ☐ Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 🗲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) MD D69568 10/2/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Rd, Rockville, MD 20852 A-Chilakamassi, MD 31. Date filed (Month, Day, Year) State OCT 05 Registrar

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	Physicia	n/	1. Decedent's Name Paul F		-								2. Date of Death Day October 3, 2012 3. Time of Death 11:30 A				
p	Medic Examin		4a. Facility Name (if			ber)	7) 4b. City, Town, or Location of Deat					4c. County of Death				$\dashv$	
~ ~	<i>)</i>		149 So	uth Ri	tters L		last hirth		Owing	gs Mil		Date of Birt		Balti			
ı	Funeral Director		<del>109</del> -20-6	892	XXM 2□F	7. Age (iii) yi.	Months Days Hours Min.						8. Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)  Aug. 1, 1927 Pennsylvania				
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हु है। 10e. Street and Number								10f.	Zip Code 2	1117		10g. Citizen of What Country? U • S • A •				?	
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hyglene. Depertment of Health and Mentel Hyglene. Amortant: If item 27 is marked other than "natural", or items 23a or 28a-f ahow amy injury or other traumetic event, the Medical Eveninal must be notified at once.	ρ	1 Never Marri	4 Divorced	ces? 2 D No tes. WW	□ No TATTAL T T 1 □ Yes 🗓 No							Black, White, etc. Specify: White				
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land	be file entei ⊢ ked of ic ever	일	<sup>17</sup> Father's Name (	First, Middle, Las L	t)	Deba				18. Mother's Carol	Name (Fi	irst, Middle, <b>Zahr</b> Zar	Maiden adni odni	Surname) <b>ck</b> L <b>ch</b>			
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2012 32038 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1, Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day Year September 27, 2012 **Medical Examiner** Sharmel M. Evans 1736 hrs 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Maryland General Hospital Baltimore 5 Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director 216-86-2548 04/24/1965 1 M Country) MD 47 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits nr 28a-f show MD N/A Baltimore 1 XYes 2 No be notified at once, Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21229 10 N. Abington Ave. 238 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "untural", more other tranumite event, the Medical Examiner in Specify: Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: è 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) McDonalds 9th Grade Food Services 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Diana Speaks Leon Evans 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Abington Ave., Baltimore, MD 21229 Diana Evans (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/09/12 Baltimore, Mt. Zion Cem. mportant: Donation 5 Other Specify: 21 Signature of Funeral Service Licenses <sup>2</sup>ටුර්පුණුර්ල්ම් ග්රීම්ම්wn Jr. 2140 N. Fulton Av Funeral Home PA Ave., Baltimore, MD2121 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical a Heroin Intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Sa X UNPENDED AMENDED 23a, pt. II, 27, 28a-f, per me, g932 10-10-12 sm the attending physician ed for use as the burial -Physician/Medi law requires that the death certificate be Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth use as t 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? 4 Pregnant at time of death Other (Specify) detached for 1 Yes 2 No 9 V Unknown 9 Unknown O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 / Unknown Atherosclerotic Cardiovascular Disease Completed Records, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? Hospital nr Attending Physician: The ✓ Yes 2 No Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 0OA 1 🗸 Yes After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending 1 Yes 2 X No unknown fd 4:53 pm 2 Accident fd 9-27-12 Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2618 Woodbrook Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide determined (Specify) Fd: Residence Homicide Baltimore, MD. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E September 28, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD 31. Date filed (Mo 32. R gistrar's Signature State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2012 12:17PM M Walter Richardson Farrow October Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery North Bethesda Brighton Gardens of Tuckerman Lane Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hou*r*s (Month, Day, Year) 577-16-5525 Director 1 X M 2 □ F 90 October 12, 1921 North Carolina Usual Residence of Deceden 10d. Inside City Limits l Hygiene. other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2X No Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 United States 14800 Pennfield Circle #309 Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: If Yes, Give White WWII leted I 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working (Give kind of work done of life. DO NOT use retired) Compl College (1-4 or 5+) Elementary/Secondary (0-12) Broker Insurance permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie May Wicker George Washington Farrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22201 1806 North Wayne Street, Arlington, Virginia Patricia R. Pengra/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 4, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, . Signature of Funeral Service License Bethesda-Chevy Chase, Inc. Maryland 20814 M01173 Kullia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Congestive Heart Failure Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, Due to or as a consequence of): Examine it any leading to immediate cause. Enter Underlying Cause (Disease or injury Atrial Fibrillation and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hypertension Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the 24 hours after death.

2 hours after death.

Promeral Director: After this certificate has been signed by the attending plately filled in by the funeral director, page 2 should be detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 🗌 No 1 🗌 Yes 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, 28c. Injury at 27. Manner of Death Certificate: X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 3, 2012 M-D D30132 30. Name and actores of person who completed cause of death (Item 23a) (Type, Print) 2041 14812 Physicians Lane #161, Rockville, Maryland Ghosh, M.D. 31. Date filed (Montr, Day, Year) 0 5 2012 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Claudia Rose Ford October 2012ª 1741 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford County Harford Memorial Hospital Havre de Grace 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F 215-12-8527 May 20, 1920 Director 92 Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford County Street 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1015 Federal Hill Road 21154 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give 3X Widowed 4 □ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Home Maker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Lombardi Josephine Larbardi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Streett (Daughter) 1015 Federal Hill Road, Street, Maryland 21154 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem Park Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oct. 8, 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremetion Services - Bel Air cevos 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) executed A To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran. that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 1 Live Birth
4 Pregnant a
9 Unknown Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death Yes 1 ☐ Yes 2 ¥ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires t 24 hours after death. 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Bowel 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner to the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier Does 9855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) union AVR Havre de Grale MD 21078 State egistrar's Signatur OCT 0 5 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 32041 Barry Jay Foxman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year September 28, 2012 **Medical Examiner** 1310 hrs BARRY JAY FOXMAN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pikesville 27 Cedarwood Circle **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Hours Director 1XM 2 F Country) 212-50-2326 Yrs 62 07/16/1950 MD Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 'natural", nr items 23a or 28a-f show Examiner must be notified at once. 1 Yes 2 X No Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", nr items 23a or 28a-f sho BALTIMORE PIKESVILLE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 27 CEDARWOOD CIRCLE 21208 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: WHITE <u>ک</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be IRVIN FOXMAN RUTH GOLDSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD ROTHSCHILD/BROTHER-IN-LAW 3809 THOROUGHBRED LANE, OWINGS MILLS, 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other place) 09/30/2012 4 Donation 5 Other Specify SHAAREI ZION CONGR. BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licen SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and (Medica) Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical  $\square$  AMENDED 23a, 27, per me, g932 10-19-12 sm X UNPENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day 2 📗 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ned by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been suneral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical the Hospital or Attending Physician: 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA ۵ 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending 1 Yes 2 No 2 Accident Investigation within 24 hours after d To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Egis State Registra

DHMH 17 Rev 1/2001 OCME 2006

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ann Gartside 200 PM Ruth 10 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE FRANKLIN SQUARE MEDICAL CENTER ROSEDALE Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Min. 214-38-5363 Director 1 🗆 M 2 🗶 F 07-29-1940 Baltimore MD 72 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director or 28a-f st notified a 1 🗆 Yes 2 🛣 No **Baltimore** White Marsh Maryland hours after death with the 10e. Street and Number 10g. Citizen of What Country? 23a or and Mental Hygiene. is marked other than "natural", or items 23a oi aumatic event, the Medical Examiner must be ! Funeral 11112 Bird River Grove Road 21162 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE If Yes. Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) IT Manager Retail 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Julia C. Lingner 2 Robert C. Freeman permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21162 11112 Bird River Grove Road, White Marsh MD Catherine Wood - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Holly Hill Mem Park 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-08-12 Baltimore, Maryland <sup>22. Name and Address of Eaclity</sup> Leonard J. Ruck, Inc 5305 Harford Road, Baltimore, Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death DAYS Immediate Cause (Final Physician/ BACTERIA SEPSIS WITH disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, if 2: y, leading to him ediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of g physician and as the burial-transit The law requires that the death certificate be executed UROSEPSIS that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical AMYOTROPHIC LATERAL SCIEROSIS Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No for Day Pregnant at time of death P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed the should be det 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an has performed? X Yes 2 □ No Division of Vital Hospital or Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 № Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 M2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the 16st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 10 30. Name and address of person completed cause of death (Item 23a) (Type, Print) BALTIMORE 9000 FRANKUN SQUARE CARRIE 31. Date filed (Month. 62. Registrar's Signature

DHMH 17 Rev 06-2011

State

Registrar

park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Mary Clare Guntner 5:55P Medical October 02 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Hours Director 215-16-5551 91 1 □ м ЖХ г Yrs June 14, 1921 Baltimore, Marylan item 27 is marked other then "neturel", or items 23e or 28a-f show other treumatic event, the Medical Examination sust be notified all 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 8306 Nunley Drive Apt. D 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2XXXNo 3 ☐ Widowed 4 ☐ Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 6 Be permit. Page 1 and 2 should be filed Department of Health end Mental Hy Important: If item 27 is marked ott eny injury or other treumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Sullivan Elizabeth Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Gregorek (Daughter) 3 Quail Ridge Court Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) sacred Heart of Jesus Dundalk, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville D 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Ent r the Lisease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. Lis only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ END STAGE RENAL DISEASE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Indulying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical nding p. IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month eral Director; After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached t Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗆 Nursing Home 5 🗆 Residence 6 🕷 Other (Specify) HOSPICE 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifi 29c. License number Q, person who completed cause of death (Item 23a) (Type, Print) **JACKIE** 2300 DULANEY VALLEY RD. JONES, TIMONIUM, State

Registrar

p.m.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#7perFH, #26perPHYS, G932, 10/5/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 25 Physician/ GENENDLIS SEPTEMBER 2012 07:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2699 DAYSPRING DRIVE HAMPSTEAD CARROLL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Days Min (Month, Day, Year) 378-26-6799 Director 1 X M 2 □ F 84 <del>-76 Yrs.</del> 09/24/1928 MT Usual Residence of Deceden item 27 is markad other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exercitor must be notified at filed within 72 hours after death with tha Maryland al Hygiana. Al Hygiana. d othar than "natural", or Items 23a or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No CARROLL HAMPSTEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2699 DAYSPRING DRIVE 21074 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) BALTIMORE CITY Elementary/Secondary (0-12) College (1-4 or 5+) 5+ ASSISTANT SUPERINTENDENT PUBLIC SCHOOLS Be permit. Page 1 and 2 should be filed Department of Haaith and Mental Hy Important: if item 27 is markad oth any linyry or other traumatic evant 2029. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MORRIS **GENENDLIS** LILIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE GENENDLIS 2699 DAYSPRING DRIVE, HAMPSTEAD, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other p MIKRO KODESH BETH ISRAEI 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/28/2012 BALTIMORE, MD 21. Signature of Funeral Service Limbur 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Enysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): use as the burlal-transi onacs Hospital or Attanding Physician: The law equires that the death certificate ba exacutad attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy ę Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this cartificate 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 25 ER/Outpatient 3 I DOA within 24 hours after death.

To the Funaral Director: After thi completely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 25 12012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Us,/Kens 3449 av105 39 Homore, 31. Date filed (Month, Pay, Year) 0CT 0 5 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32045 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Celeste Helen Griggs October 0 6:12am M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4814 Valley Forge Road Randallstown Baltimore If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 214-38-9787 **Director** 1 □ M 2 🗶 F 69 18, Usual Residence of Decedent fshow 10a. State death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2X No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4814 Valley Forge Road USA ral", or items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married ☐ Yes 2 X No 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Assistant Medical Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည William Fox, Anna Mae Birch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Denise Smith Daughter 3825 Shiloh Ave., Apt.4, Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/09/12 Alphonsus Cem. Woodstock, MD 22. Name and Address of Facility 11824 Reisterstown Road her Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ on certire disease or condition Medical resulting in death) Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown After this certificate has been signed by the a funeral director, page 2 should be detached to Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 - No မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending s after death.

I Director: After din by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 5 2012

-Jack

32. Registrar's Signature

Winters

address of person who completed cause of death (Item 23a) (Type, Print)

3

stenstown

2

Please Type or Print in Black Indelible Ink 2 Ensure All Copies Are Legible.

AMEND ITEM#23a, perfhys, 6932, 10/37 2012, WS

State of Maryland / Department of Health and Mental Hygiene
Amend #25, per mE G932 10/12/12 trt

Certificate of Death

Reg. No. 2012 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** September 99, 2012 4c. county of Death Kaprece Gilbert
a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** Date of Birth (Month, Day, Year) 12–29–1984 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 😾 F PENNA. 177-72-1890 27 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a State 10h County 1√ Yes 2 No Director PENNA. YORK YORK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 1107 W. POPLAR ST. 17404 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates: Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12)
-12-College (1-4 or 5+) is marked other than OUALITY INSPECTOR K.S. TOOLING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental MICHAEL J. GILBERT NINA T. LOVETT ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 any Injury or other tra Department of Health NINA T. LOVETT-GILBERT (MOTHER) 1107 POPLAR ST. YORK, PENNA. 17404 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 Clemation 3 K Removal from State 1 XBurial SUSQUEHANNA MEM. PARK 10-6-2012 YORK, PENNA. 4 Donation 5 Other (Specify) of 5 meral Service Licensee JONATHAN .D. HIBNER 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a subgrachnoid hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b. aneurysm Examiner as a consection of of the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 412 事人会のトー 十分メヤン Mission of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Director: After this certificate has 2 No 2 No 1 Tyes 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: I or Attending F after death. 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 🗌 Homicide within 24 hours a To the Funeral L the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 72787 September 30, 2012 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) KOCA Bluth OSKUG 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 11595

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

\*State of Maryland/ Department of Health and Mental Hygiene 2012 32047

		1- For State Registrar		Ce	ertificat	e of	Death			R	eg. No.	, . –	
Physi		1. Decedent's Name (First, M	ddle,Last)						2	2. Date of Dea Month	ith Day Yea		3. Time of Death
Medical Exa	mine	oregory mir								Septembe	er 24, 2012		1906 hrs
4		4a. Facility Name (if not instit		number)		41	c. City, Town,	or Locatio	n of Death		4c. County of	f Death	
		4519 Fairfax Road					Baltimore						
Funer		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthda	ay)	If Under 1 Y	ear IfUr ays Hou	nder 24Hrs. urs Min.	8. Date of Bi	th (MM/DD/YYYY	9. Birth Foreign	
Directo	or	153-40-6159	1 M 2 F	6	4	Yrs.	WOILUIS	ays Hot	JIS IVIIII.	Aug 6	1948	Cou	ntry)New Jerse
		Usual Residence of Deceden											
(ue A		10a. State 10b. Cour	ity	10c. City	y, Town or	Locatio	n						10d. Inside City Limits
and	를 <b>급</b>	MD			Balt	timo	re						1 Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number					10f. Zip Code		_	1	0g. Citizen of Wh	at Count	try?
the I			Road #1					2121	5		USA		
0036 within 72 hours after death with the Maryland jene.	Funeral Director	11. Marital Status	. 1	ecedent Ever in U	J.S. 1					cify Yes or No			an Indian, Black,
death		1 X Never Married 2	Married 1 Yes	Forces?		II Yes	s, specify Cub	an, wexic	an, Puerto R	ican, etc.)	White	, etc.	
L T		3 Widowed 4	Divorced If Yes, Give Y or Dates:				res 2 X		-		Specify: -		ack
nours							s Usual Occup st of working li				16b. Kind of Bus	siness/In	ndustry
6 n 72 l	Completed	Elementary/Secondary (0-1		(1-4 or 5+)			ng Exe				Bevera	ge (	Company
withii jene.		12 17. Father's Name (First, Mid	4		<u>i                                      </u>	sal	espers				-		tribution
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21215-0036 21215-0036 Judy be filed within 7 IMental Hygiene.	Be C				I 10h N	Apilipa	Address (Str				agby nber, City or Towr		7ia Cado)
Shoul shoul	2										e, NJ 08		zip code)
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental 1 inner: If item 27 is marked		Beverly Gibso	on/sister	1.20b			on (Name of			Date	20c. Location -		Cwn State
of He		1 Burial 2 Crema	tion 3 Removal		crematory			,,					
Pag ment tant:	5	4 Donation 5 X Other	Specify: in St	ate	Or	1-S					Balti		
Baltimore, permit. Pages 1 as Department of He Important: If ite		21. Signature of Funeral Serv	d S/ Wade,	Direct	ox i	22 Na Sta	me end Addre	ss of Faci	Board	1 655 W	. Baltin	nore	Street
— KEA.		X COVVII	m			Ra T	ltimore	. MD	2120	)1			
Physicia Medica		23a. Part I. Enter the disease, failure. List only one cau	or complications that use on each line.	caused the deat	h. Do not e	nter the	mode of dyin	g, such as	s cardiac or r	espiratory arr	est, shock, or hea	ırt.	Approximate Interval Between Onset and
Examine		Immediate Cause (Final disea		ive Atheros		ardio	vascular D	isease					Death
2		or condition resulting in death	Due to (or as	a consequence	of):								
	6	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):							-	
		cause. Enter Underlying Cau (Disease or injury that initiate	se										
-p :	Examiner	events resulting in death) La		a consequence	of):								
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be ey	edical	UNPENDED	AMENDED										
760, ficate be		23b. Was decedent pregnant i		, outcome of pre birth		7 5.40	I death 3	Ecto	pic pregnano	714	23d. Date of o		ay Year
certi		past 12 months?		nant at time of d		=	er (Specify)		pic pregnark	-,	World	0.0	ay roa
Box 687 ne death certification the attending	Physician	1 Yes 2 No 9	Jnknown g Unk	nown		0.110	,, (-,,,				1		
~ = 57	3 J DL		ditions contributing	to death but not	resulting in	the un	derlying cause	given in	Part I.	1			ne cause of death?
, P.C	A P	Prostate cancer, D	iabetes mellitus							1 Yes	2 <b>✓</b> No 3	Proba	ably 4 Unknown
requi	Completed									24a. Was autop			opsy findings available empletion of cause of
e law	2 2 2 2									perfo	rmed? de	eath?	_
tal Recian: The		25. Was case referred to med	ical				26 Pla	ce of Dear	th (Check on		2 No 1	Yes	2 No
	o Be (	examiner?	Hospital:	Inpatient 2	ER/Outpa	atient		Other <sub>4</sub>		· · · · · · · · · · · · · · · · · · ·	Residence 6	Other:	Scene
of Vi ng Physi After this	g   F	27 Manner of Death	28a. Dat	e of injury	28b. Tim			jury at Wo			how injury occurre		
Da Carlo	cation:	1 ✓ Natural 5 D P	(Mon	th, Day,Year)			1	Yes 2	No				
Si Gea		2 Accident In	vestigation 28e. Pla	ice of Injury - At I	home, farm.	. street.	factory, office	building.	etc. 2	8f. Location (	Street and Numbe	r or Rur	al Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Function	Certific	3 Suicide 6 C  4 Homicide	ould not be etermined (Specif)				7,			or Town, S			
lospi 4 hou uner			Physician: To the b	est of my knowle	dge death	occurre	ed at the time	date and	nlace and d	ue to the caus	se(s) and manner	as state	4
the Hos hin 24 h	Medical	(Check only 1 Certifying one) 2 Medical E	xaminer: On the basis	of examination									
2 ½ £	Š Ž	29b. Signature and title of cer	and manner	stated.			29c, Lice	nse numb	er		29d. Date signe	ed (Mont	th, Day, Year)
		027					0.0	M.E.			September	25, 20	12
		30. Name and address of pers	on who completed so	use of death (Ito	m 23a)								
		Donna M. Vincenti,		Medical Exa		900 V	V. Baltimo	e Stree	t, Baltimo	re, MD 21	223		
	State			Registrar's Signa									
	istra			A	has	a No	1						
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OCME 2006													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician/ HUANG Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Withwest HOSPITA Kandallstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 215.96.3798 Director 1 M 2 K China Usual Residence of Decedent t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be metified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Baltimore MD Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 Chiva 4012 Lawnnth Koad 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by filed within 72 hours efter Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Asian 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) COOK Loth arade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 end 2 should be Huang Fa LIU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sugiong Lin 409 Old Milford Mill Road Pikesville MD 21208 /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Page 1 Department of Important: If it any injury or o 1 M Burial 2 Cremation 3 Removal from State 10/09/2012 orraine Park 4 Donation 5 Other (Specify) Windsor Milli MD Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughn C. Greene Funeral Services SpertyRoad Bandallstown MD 21133 23a. Part 1. Enter the disease, or complications shock, or leart failure. List only one cause disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ARKINSONS Priysiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease of Lijury Hospital or Attending Physician: The law requires that the deeth certificete be executed ettending physicien and for use es the burlal-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was ded edent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 mont Month Day Pregnant at time of death To the Hospital or Attending Physician: The law requires that the cee within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be deteched? 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by neumoNIA Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 🗗 No ျု 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 D Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUR State OCT O Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Deborah Hair Veronica 3:30 PM 10 03 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MiDwood BALTIMORE AVENUE If Unde 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 XF Months (Month, Day, Year) 8 214-50-3741 Days Hours Min. 64 Yrs. **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 □ No BAUTIMORE 10g. Citizen of What Country? Funeral 4905 MIDWOOD 21212 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes Give 1 ☐ Yes 2 Mo Specify: Completed 3 Widowed 4 Divorced BLACK Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) OSPITAL 4DMINISTRATOR BAYVIEW HOSPITAZ marked other Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o RAYMOND should be Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hair DSPRING LANE. BACTO, MO. 21212 Nicole DAUGHTER. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 7 5 ☐ Other (Specify) 10/8/12 CremATION CIR OF BALTIMORE, MD 21. Signature of caral Se vice License 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCKS BAUTIMORE, Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ metostatic conun welver disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami and -transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) the burialattending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 XNo မှ 1 
Yes this 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending work?
1 Yes Accident 2 🗋 No Investigation n 24 hours after deat e Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) Not D0061361 mD 10 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bellinore, mp 21287 - Wortes 600 N. Wolfe St 20,1 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

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	•	For State Registrar	State of Maryla		epartment of Certificate of		d Mental H	ygien Reg. N	2010	2 32050
Physiciar Medica		1. Decedent's Name (First, Middle, La	Hanaia	1	Sr		2. Date of D Month SPOTEN	Death	ay Year 26 7017	3. Time of Death
Examine		4a. Facility Name (if not institution, give	1. 60.		4b. City, Town,	or Location of Do		-	c. County of Dea	
Funeral Director			Sex 7. Age (În yrs	s. last birtho	ay) If Under 1 Year Months Days		Irs. 8. Date of B	irth Day, Year)	9. Bi	irthplace (State or Foreign ountry)
	ڀ	Usual Residence of Decedent  10a. State  10b. County	90	) Yr City, Town o			4/17	193	22 No	10d. Inside City Limits
Marylar 28a-f sh otified	Director	MD NI	A	P	11-	ore				1 Yes 2 No
with the 23a or ust be n	Funeral D	10e. Street and Number	naheeter	atra	10f. Zip Code	21211		10g. C	Citizen of What C	country?
or items		11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 \( \subseteq \text{No} \)	J.S.	13. Was Decedent of I	Hispanic Origin? Dan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	)-	14. Race - Am Black, Whi	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	eted by	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Dates.		1 🗆 Yes 2 🗐 N			,	Specify:	Hack
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t, Mand 2 sho ealth an m 27 is ner trau		Mrs. Wendy	Rigby	196.1	Mailing Address (Street	soud P	Kwu Ba	er, City o	or Town, State, Z	21229
Baltimore, bernit. Page 1 and bepartment of Hes mportant: If item iny injury or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery,	isposition (Name of crematory or other pla	ace)	Date	20c. f	ocation - City o	r Town, State
Baltii permit. F Departm Importa any injui		21. Sign and of Funeral Service Licen		urris		esa of Facilit	uss Fun	eral	Harry	P.A.
		23a. Part 1. Enter the disease, or comshock, or leart failure. List only	nplications that caused the de	ath. Do not	a.2.2.7 Two	ing, such as card	h AVL.	arrest,	te, M	Approximate
Phynician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a Acute	Rei	nal Fai	lure				Interval Between Onset and Death
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executed ian and urial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):					J.	
- E & 6		resulting in death) Last	Due to (or as a conse	quence of):						
6876 ertificate ding phy se as the	/Wed	IF FEMALE:	23c. If yes, outcome of pregr	nancy						
Hamie   , Edgav SR  Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the by	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown	1 Live Birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death	3  Ectopic pregnar 5 Other (specify)	ncy		Ì	23d. Date of de Month	elivery Day Year
P.O. P.O. Sthat the	by Ph	Part II. Other significant conditions of	contributing to death but not re	esulting in t	he underlying cause g	given in Part I.				to the cause of death?
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Fdagv	Completed by						<ul><li>autoper</li></ul>	opsy formed?	prior to death?	completion of cause of
Aital Sician:	lo Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▶ No	Hospital:		Ott	Place of Death (C			- III ou - 10	
n of / n of / ing Phy Viter this funeral o		27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Tim	e of 28c. Inju	ry at rk?	g Home 5 Res 28d. Describe			city)
Division  Bivision  Safer death  Safer death  In Director: Afted in by the fur	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not be determined	be 280 Place of trium. At h	home, farm		Yes 2 No				ural Route Number,
Fam E , Edgay Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Phy	ysician: To the best of my know	wledge, de	ath occurred at the time	ne, date and plac	City or To	cause(s)	and manner as s	stated.
the Ho thin 24 h the Fu		(Check 2 Medical Examonly one) 3 Certifying Nur	niner: On the basis of examinations of the best of the	ion and/or ir	vestigation, in my opin dge, death occurred at	nion, death occurre the time, date an	ed at the time, date	and place the caus	e, and due to the e(s) and manner	cause(s) and manner stated. as stated.
or No sign		29b. Signature and title of certifier	- M	- MI	29c. Licens	27690	)	29d. D.	ate signed (Mont	in, Day, Year)
(6)		30. Name and address of person who	1- 0	a 10/		Balti	MADO	Ma	cyland	21229
State Registra		31. Date filed (Month, Day, Year)	2012 32. Registrar's Sign		barr	, waiti	more.	1-14	yana	31301

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ Year 2012 Harris 10:35 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death SANCT MONTGOMER 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 1 🗆 M 2 📈 F or 28a-f show 10a, State Examiner must be notified at 10c. City, Town or Location Director URTONS 1 Yes 2 No 10g. Citizen of What Country? **Funeral** or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Maryland 21215-0036 2 No "natural", 1 🗌 Yes Specify 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GALLOWA permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) D14UGhtt 9b. Mailing Address (Street and Numbe Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementin ascula disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner bo vascu iseas+ R Sequentially list conditions, Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Examir sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last ng physician a as the burial Physician/Medical requires that the death certificate be the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Abrillation Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has page 2 autopsy performed? certificate 1 Yes 2 No Yes 2 No Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \( \subseteq \text{Yes} Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🗖 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year)

3

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

a Hear (asthe

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mary				Mental Hy	giene				
	_		State Registrar	Cer	tificate of L	Death	<del> </del>	Reg. No. 20 2	32052			
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Hatte C. Hill				2. Date of De Month	ath Day Year 201	3. Time of Death			
	Examir	ner	UNIVERSITY of MD (	ents.	4b. City, Town, or Bulfin	4c. County of Dea	ine City.					
	Funeral Director		220-38-9163	yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11/18	y, Year) Co	thplace (State or Foreign nuntry) ryland			
	faryland Ba-f shov tified at	ector		c. City, Town or Loc Bal	timore		-1		10d. Inside City Limits  Yes 2 □ No			
	with the N 23a or 28 ust be no	Funeral Director	10e. Street and Number 324 Bigley Ave.		10f. Zip Code 212	 27		10g. Citizen of What C	ountry?			
9003	e filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 □ Mole of Yes, Give Year or Dates.	If	√as Decedent of Harabay Yes, specify Cuba	in, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:				
21215-0036	within 72 ho giene. ier than "nal ist the Medica", the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12th Grade  College (1-4 or 5+)	(Give k	ent's Usual Occup ind of work done of NOT use retired) vites D	during most of wor		Gensis E Catonsv				
Maryland	should be filed and Mental Hyg I smarked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) Alexander Richards	·		18. Mother's Nar		Maiden Surname)				
	○ = 6 t		19a. Informant's Name/Relationship (Type, Print)  George W.E. Hill (Husband	19b. Mailing	g Address (Street a Gigley	and Number or Ru	ral Route Numbe Baltim	r, City or Town, State, Zi	o Code) 1 2 2 7			
Baltimore,	Page 1 and ment of Hes ant: If item ury or other			0b. Place of Dispos cemetery, cremonsite		ory [0]	Date 02-112-	20c. Location - City or Baltimo				
Balt	permit. Page Department Important: I any injury or		21. Signature of Funeral Service Licensee	11 - 30	)sephodis	s <b>Brown</b>	Jr. Fu	neral Hom Baltimore	e PA , MD21217			
	nysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the cannot shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	death. Do not enter	the mode of dying	g, such as cardiac	or respiratory an	est,	Approximate Interval Between Onset and Death			
	Examiner		Hutow C	sequence of):	peni	ė			days			
	uted d ansit	Examiner	Sequentially list conditions, b. Highly learning terms of all the cause. Enter Underlying Cause (Disease or Injury that initiated events c.									
09	ate be executed hysician and the burial-transit	dical Ex	d									
. Box 6876	the Hospital or Attending Physician: The law requires that the death certificate be executed the 24 hours afford eath.  The Funeral Director death.  The Funeral Director, page 2 should be detached for use as the burial-transity filled in by the funeral director, page 2 should be detached for use as the burial-transity.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ 1 ☐ Live Birth 2 ☐ 1 ☐ Vive Birth 2 ☐ Vive Bi	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year			
ds, P.O.	requires that the peen signed by should be deta	by	Part II. Other significant conditions contributing to death but not	t resulting in the un	derlying cause giv	en in Part I,		bacco use contribute to	the cause of death?			
Division of Vital Records,	l <b>Physician</b> : The law rec r this certificate has bee eral director, page 2 sho	Completed					24a. Was a autop perfo	rmed? prior to death?	topsy findings available completion of cause of			
ta	cian: ertifica ector,	Be	25. Was case referred to medical examiner?			ace of Death (Chec		2/3-430	2 2240			
Ĭ.	Physi this c	으	1 ☐ Yes 2 Hospital: 1 ☐ Inpatient 2 27. Manner of Death 28a. Date of injury	2 ER/Outpatient 28b. Time of		4 U Nursing H		ence 6 Other (Spec	ify)			
ion o	l or Attending Ph after death. Director: After th d in by the funeral	Certificate:	1 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	r) injury			28d. Describe h	ow injury occurred				
Divis	spital or A ours after eral Direc filled in by		4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	ecify)			City or Tow					
	To the Hospital within 24 hours a To the Funeral D completely filled	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 3 Certifying Nurse Practitioner: To the best	ation and/or investig	gation, in my opinio	n, death occurred a	it the time, date a	nd place, and due to the	cause(s) and manner stated.			
	on with		only one) 3 Certifying Nurse Practitioner: To the best 29b. Signature and title of certifier  A Hendi  Thy Signature and address of person who completed cause of death (I)  30. Name and address of person who completed cause of death (I)  31. Date filed (Month, Day, Year)  OCT 0 5 2012	igan	29c. License	number 8 260		29d. Date signed (Month)	n, Day, Year)			
			30. Name and address of person who completed cause of death (I	Item 23a) (Type, Pri	ron, A	10 ZZ	S GREE	OUR SA BALS	SMORE WAS			
	Stat Registra	e ir	31. Date filed (Month, Day, Year)  OCT 0 5 2012  Registrar's Sig	gnature for	les .							

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar  1. Decedent's Name (First, IV						Certifi					2. Date of D	Reg. N	00	12	37	2050
Physicia Medic	al	Charle	s Rus			chle	er						Month 10 -	_ D	ay 201	Year 2		of Death
Examin		4a. Facility Name (if not instit 18 Windso 5. Social Security Number		reet and num		A			E	Balt	Location	re			c. County of			
Funeral Director		216-34-2254 Usual Residence of Deceder	1 X	M 2 □ F	7. Age	Age (In yrs. last birthday) 76  Yrs.  If Under 1 Year If Under 24 Hr Months Days Hours Min					Min.	8. Date of Bi (Month, D 8 – 9 –		9. Birthp Count A		e or Foreign		
ryland I-f show ied at	Director	10a. State 10b. Co		ore		10c. City, Town or Location  Baltimore												City Limits
vith the Ma 23a or 28a st be notif		10e. Street and Number 18 Windso						1	10f. Zip Code 21 2 3 7					10g. Citizen of What Countr USA				es #£. No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status  1   Never Married 2   3   Widowed 4   Dividowed 4	Married	2. Was Dece Armed Fo 1 XYes If Yes, Giv Year or Da	rces? 2	S?   If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   Black,   No   1 □ Yes 2 ☑ No   Specify: V							14. Race - Black, Specify: W	White,	etc.			
nin 72 hours ne. than "natur e Medical		(Specify only Elementary/Seconday (0-		cation		+)	(C lif	e. DO N	of wor OT use	k done d retired)	during mos		ing	Ť	Kind of Busi		•	
e filed witl ntal Hygier ed other t event, th	a l	, ,	7. Father's Name (First, Middle, Last) Orlo H. Hechler							L Em		ner's Nam	e (First, Middle	, Maidei	stal n Surname)	Ser	VICE	3
2 should b Ith and Mer 27 is mark traumatic		19a. Informant's Name/Related A.	tionship (Type	e, Print)	iste	er					and Numb	er or Rura	Kaou Route Numb Rd., W	er, City o				21157
Page 1 and lent of Hea nt: If item ry or other		20a. Method of Disposition  1  Burial 2  Crema  4  Donation 5  Ot	ation 3 🗆 R			20b. P	lace of D	Dispositio	on (Nam	e of	(a)	[	5/201	20c.	Location - C	ity or To	wn, State	
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n 24 hou in 24 hou ae Funer pleted fill	Medical	(Check 2 Image Med	ical Examine	er: On the bas	sis of ex	amination	and/or i	nvestigat	ion, in r	ny opinio	on, death c	occurred at	d due to the c the time, date ce, and due to t	and place	ce, and due to	o the ca	use(s) and i	manner stated
Vithi Com		29b. Signature and title of ce	ertifier						290	License	number	7		29d. D	ate signed (	Month, I	Day, Year)	
1		30. Name and address of pe	rson who cou	npleted aus	se of de	ath (Item	23a) (Ty	pe, Print)	Mo	an	W	ve	1 lo	A.	M)	21	230	5
Sta Registra		31. Date filed (Month, Day, You OCT 0	2012	2. R	legistrar	r's Signat	ure	are	1									7

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 10:23 AM 2012 HUGHES **Physician** ORGE Uctobe /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Racility Name (If not institution, give street and number) **Examiner** N/A Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth FEB. 2<sup>ear</sup> 1946 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours **Funeral** 66 584-58-2441 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 XYes 2 □ No Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. **Funeral Director** BALTIMORE N/A MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21206 U.S.A. 4230 BERGER AVENUE · death v 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White, etc. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 X Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK þ DOMINICAN 3 Widowed 4 Divorced 16h Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5 College (1-4 or 5+) RESTAURANT COOK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HUGHES Pages 1 and 2 should be SILUANI LECO **EMILIO** ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 19a. Informant's Name/Relationship (Type. Print) 4230 BERGER AVENUE, BALTIMORE, MARYLAND CRYSTAL PEREZ/ NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition BARRIO CHINO 1 XBurial 2 Cremation 3 X Removal from State ⊋EMETERIO RIO HAINA 10/13/12 DOMINICAN REP. 4 Donation 5 Other (Secity) 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD 2 21. Signature of Fun wice Licenses 21231 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardica ric Shock
Due to (or as a Insequence of): Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** ystemic Scheros Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 2 No funeral director, page 2 should be detached Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate has 1 ☐ Yes Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No 1 🗌 Yes မ this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After it Injury 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 6 ☐ Could not be 3 Suicide determined City or Town, State) filled in by 4 Homicide

completely

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

one)

(check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Medical

and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DD 000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Theodore Hoyles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 32055 **UNK UNK** Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1624 hrs Medical Examiner September 28, 2012 Theodore Hoyles 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 3710 Dorchester Road If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Foreign Country) Days Hours Director 08-08-52 SC 60 219-98-5099 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No NA Baltimore MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2121 Braddish Avenue 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. Armed Forces? African 1 X Never Married 2 Married 2 X No Yes 1 Yes 2XX No specify: Specify: American If Yes. Give Year 4 Divorced 3 Widowed é 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Housing 9th Grade Painter NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora Lee Be Robert Hoyles, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)29/3019a. Informant's Name/Relationship (Type, Print ) ဥ 163 McFadden Street Rock Hill, South Carolina Doris H. Earle-Sister 20c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rock Hill, SC 10-05-12 Barber Mem. Cemetery 4 Donation 5 Other Specify. 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, Maryland Approximate Interval 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death /Medical aNarcotics (Morphine and Tramadol) and cocaine Intoxication Immediate Cause (Final disease Èxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, # any, leading to immediate cause. Enter Underlying Cause Examiner Due to for as a consequence of: (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED 23a, 27, 28a-f, per me, g932 10-10-12 sm ed by the attending physician a detached for use as the burial -X UNPENDED the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed by uneral director, page 2 should be detach 1 Yes 2 No 3 Probably 4 V Unknown <u>۾</u> Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25 Was case referred to medical æ examiner? Other 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Yes 2X No unknown 1 Natural 5 Pending death. Director: the fd 9-28-12 fd 16:20 pm 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3710 Dorchester Rd. Baltimore, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. l in by 3 Suicide 6 X Could not be within 24 hours a To the Funeral I (Specify) Boarding House Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 29, 2012 O.C.M.E. alues 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Ana Rubio M.D., Ph. D. strar's Signature 32. R 31. Date filed (Month, Day, Year) State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month JERRY RAY HUGHES SEPTEMBER Medical 28,2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3015 DUNDALK AVENUE BALTO. DUNDALK Social Security Number If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours 230-68-2157 65 **Director** 1 X M 2 🗆 F VIRGINIA MAY 18,1947 28a-f shov 10a. State with the Maryland items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director BALTO. DUNDALK 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 3015 DUNDALK AVENUE Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner ms. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ξ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. WHITE 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/S 12TH Secondary (0-12) College (1-4 or 5+) SELF-EMPLOYED MACHINIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MAMIE DEVOR. WALTER CARL HUGHES, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3015 DUNDLAK AVENUE DUNDALK, MD. 21222 JULIE HUGHES DTR. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If if any injury or or 1 X Burial 2 Cremation 3 Removal from State 10-2-2012 RICH CREEK, VA. 4 ☐ Donation 5 ☐ Other (Specify) SUNRISE MEMORIAL 21. Signature of Furieral Service Live 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. BALTO. MD. 21224 6224 EASTERN AVENUE se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, total one cause on each line. 23a. Part 1. Enter the dis shock, or heart failu Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) whout Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Exami spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eata Director: After this certificate has been signed by the attending physician and rilled in by the Interest of After this certificate should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Onknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 0 1 Yes 2 No 25. Was case referred to its Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner A ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred **V** atural 5 Pending Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completely filled the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year,

OCT O

man

e and address of person who completed cause of death (Item 23a) (Type, Print)

			for State Registrar	tate of Marylan		artment of He tificate of De			giene Reg. No. 2012	32057	
	Physicia Medio		1. Decedent's Name (First, Middle, Last) Charles Carroll	Heck				2. Date of Dea		3. Time of Death 5:25p M	
	Examin		4a. Facility Name (if not institution, give street ManorCare Health	Services		4b. City, Town, or Lo	n			imore	
9	Funeral Director		5. Social Security Number 217-24-4520 S. Social Security Number 2 S. Sex M. M. Usual Residence of Decedent	7. Age (In yrs. la	st birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birt		rthplace (State or Foreign ountry) MD	
	faryland 8a-f show tified at	ector	10a. State 10b. County Baltimore	10c. City			·	10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
id II ( Z I Z I D-0030) be filed within 72 hours after death with the Maryland ental Hygiene.	with the Ns 23a or 2	Funeral Director	10e. Street and Number 618 Dunwich Way			10f. Zip Code 21221			10g. Citizen of What CoUSA	ountry?	
	e filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 XMarried 1 If S Widowed 4 Divorced	/as Decedent Ever in U.S rmed Forces? X Yes 2 □ No Yes, Give ear or Dates.	1	Vas Decedent of Hispa i Yes, specify Cuban, i Yes 2 XNo		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W		
-61717	l within 72 hoi ygiene. her than "nat it, the Medica	e Completed			(Give I	lent's Usual Occupation ind of work done during NOT use retired)  CKSMith		sing	16b. Kind of Business Industry  County Emplo		
ryland	Q = 3 0	To Be	17. Father's Name (First, Middle, Last) Charles F. Heck		T		Grace	Manni			
e, Ma	nd 2 shc ealth an <b>m 27 is</b> ner trau		19a. Informant's Name/Relationship (Type, Pr Patricia Heck W 20a. Method of Disposition	ife	618			ssex M	r, City or Town, State, Zi aryland 2	1221	
saltimore	t. Pag tmen tant: tant:		1  Burial 2 X Cremation 3 Remode 4 Donation 5 Other (Specify)  21 Signature of Funeral Service Licensee	usal fram Ctata C	lanti	c Crem		01/12	Glen Bur		
D	permit Depar Impor any in	/	23a. Part 1. Enter the disease, or complication	ons that caused the death	Т	homasAll	enPA 7	090 Ri	dge Rd Ha	nover MD	
7	Physician/ Medical		shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	ise on each line.	nun		1	ra to li		Approximate Interval Between Onset and Death	
garant d	Examiner	her	Sequentially list conditions, b. b. — if any, leading to immediate	Due to (or as a consequ	ctutu	i di	Jerse.	to li	rer		
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, box oc	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	Was decedent pregnant in the past 12 months?  1  Yes 2 No  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)							
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II Kecords,	n: The law re ificate has be or, page 2 sh	Completed	25. Was case referred to medical			26 Plane	e of Death (Chec	1 🗆 Yes		utopsy findings available completion of cause of	
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on or	ending P eath. or; After tl the funera	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	8a. Date of injury (Month, Day, Year)	28b. Time of injury	work?	s 2 🗆 No	28d. Describe h	ow injury occurred		
DIVISION	oital or Att urs after d rral Direct illed in by t		4 Homicide determined	Be. Place of Injury - At ho building, etc. (Specify,	)			City or Tow			
	the Hosp thin 24 ho the Fune mpleted f	Medical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner: O only one) 3 Certifying Nurse Pra	n the basis of examination	n and/or invest / knowledge, c	tigation, in my opinion, death occurred at the til	death occurred a me, date and pla	at the time, date a ce, and due to th	nd place, and due to the e cause(s) and manner as	cause(s) and manner stated. s stated.	
	<b>₽</b>		29b. Signature and title of certifier	<u></u>		29C. License no	2749		10 -4-	MO 2 2 12 V 4	
F	(		30. Name and address of person who completed the say and Himan	u Ma	23a) (Type, F	os le	y dri	W. To	insur,	MO 2 1214	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	hark	1					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09 Month Physician/  $20\overset{\text{Year}}{1}$ TERESA C. HOWLETT 26 9:48 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Magothy Beach Road Anne Arundel Pasadena Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Months 219 18 0837 Hours Director 1 □ M 2 🔀 F 89 09 13 1923 Maryland Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits by Funeral Director MD Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 197 Magothy Beach Road 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Dental Technician Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicholas Arduin Mary Rose Elmo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 197 Magothy Beach Rd Pasadena, 21122 Nancy Bargar - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood Cemetery 10/2/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home, Signature of Funeral 169 Riviera Drive Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final FAILURE nset and Death HEART Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner ARTERY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? YMPHOMA Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 🛂 No Hospital: 2 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. wae MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #608 Hwy 1600 CRAIN

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Samuel 1020 AM C. Jackson Sestember 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bultimore Andre If Under 1 Year If Under 24 Hrs. Social Security Number 217–38–2566 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1**Ж** М 2 □ F (Month, Day, Year) 10/13/43 Days **Director** Yrs. 68 Usual Residence of Decedent or 28a-f show 10b. County 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1308 Andre Street Funeral 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Completed Specify: 3 Widowed 4 Divorced White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) Civilian Employee College (1-4 or 5+) Machinist US Coast Guard any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Jackson, Sr. Virginia Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Lynn Jackson/Daughter 3549 Roland Avenue, Apt305, Baltimore MD 21211 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State cemetery, crematory or other place)
Cremation Center of MD 10/3/12 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 E. Fort Ave, Baltimore MD 21230 Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arrhythmia disease or condition resulting in death) a Cardiac Medical Due to (or as a consequence of): Examiner Hypertensive Amero sileotic Carlovasular Diseas 1045 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician are as the burial. Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Sternosis Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 1)396660 Korsert Court MD October 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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E.

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Robert C. Durt

MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:05A M ARTHA TEFFERSON 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MARIS HOSPICE IMONIUM BATTIMORE Social Security Number 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) 252-38-3436 Usual Residence of Decedent Director 1 □ M 2 🗗 F 83 Yrs. 1929 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director HARFORD 1 Yes 2 No dgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21040 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, ģ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Completed 3 ₩Widowed 4 Divorced BLACK 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other then any injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) MACHING OPERATOR 2 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) BARBARA SISTER MO. 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State erth Amboy, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee BACTIMORE, MU1645 4905 OYK Part 1. Infer the completion that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Emer the Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) END STAGE DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute.) Examine Due to (or as a consequence of): ettending physician end for use as the buriat-transi Hospital or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records. Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy 1 ☐ Yes 2 ☐ No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 🔀 No |2 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) Division of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending eral Director: A filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE J. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State

Registrar

a.m

		- POI	artment of Health and Mental	Hygiene Reg. No.2012 32051
Physici	an/	1. Decedent's Name (First, Middle, Last)	2. Date of	of Death 3. Time of Death
Medi	cal	HELEN JUHNSON	4b. City, Towar of Location of Death	06 P A 3 30/2 16:17 PM  4c. County of Death
Exami	ner	GOOD SAMARITAN HOSPITAL	Baltimore	4c. County of Death
Funera Director		5. Social Security Number  212-44-5810  6. Sex 1 □ M 2 ♥ F  7. Age (In yrs. last birthday) 6. 7 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month	f Birth n, Day, Year)  9. Birthplace (State or Foreign Country)  MD
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ath wifens 2;	Funeral Director	3412 MAYFIELD AVENUE  11. Marital Status  12. Was Decedent Ever in U.S.  13. V	21244 Was Decedent of Hispanic Origin? (Specify Yes or	No- 14. Race - American Indian,
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Iryland 21215-0036  ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	P		PLUMIE CU	· ·
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Baltimo permit. Page Department ( Important: If any injury or once.		21. Signature Funeral Service Licensee	2. Name and Address of Facility VAughn	GREENE FUNCLING SUNS AUTIMORE, MO 21212
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	er the mode of dying, such as cardiac or respirato	ry arrest, Approximate
Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  MASSIVE ASI	PIRATION PNEUMO	!nterval Between Onset and Death
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ords, P.O. Box 68/60 requires that the death certificate be exceed signed by the attending physician is should be detached for use as the burial			End Stage Renal 23e. [	Did tobacco use contribute to the cause of death?
VITAI KECOTGS, ysician: The law requires is certificate has been sig director, page 2 should b	Completed by	Chronic Live Dinan with eichosis, a Dinase, Hypertension, Diabetes Mele	liters tepe 2. 24a.	Was an 24b. Were autopsy findings available
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DIVISION Of VITAI HECC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	Me	only one) 3		
->-0		Manie	RESODO	10/4/2012
_		30. Name and address of person who completed cause of death (Item 23a) (Type, F  AMITH SHAMIR SGOI LOCH RAVEN BO	Print) DULEVARD, BALTIMORE	MD 21220
Sta		31 Date filed (Month Tlay Year)		, , , , , , , , , , , , , , , , , , , ,
Regist	ar	OCT 0.5 2012 About A An	مرجع وا	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#5perFH, G933, 11/14/2012, WS State of Maryland / Department of Health and Mental Hygiene 1/2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20/2 26, Christine Jackson otember 2:01 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 7010 West Park Drive Hyattsville 5. Social Security Number 2126 579-54-2128 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 □ M 2 X F Months Davs Hours Min. FEB. 6 1941 Washington, DC 71 Director Yrs Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director Medical Examiner must be notified MD Prince George's Hyattsville 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a7010 West Park Drive 20783 USA , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? 1 ☐ Yes 2 🖾 No Black, White, etc. ģ 1X Never Married 2 Married within 72 hours after Black 2 should be filed within 72 hours after the and Mental Hygiene.
27 is marked other than "natural", 1 Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12th Secretary Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Isaac Jackson Rosie Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Evans-Cromer/Niece 3001 Branch Avenue #621 Temple Hills, Maryland 20748 Linda permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/4/2012 Cemetery Harmony l Landover, Maryland 22. Name and Address of Facility Signature of Funeral Service License Johnson & Jenkins Funeral Home Naphney N. 716 Kennedy Street N.W. Washington, DC 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Arteriosclerotic Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence oi). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completed filled in by the funeral director, page performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examinor?
Yes Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗀 No 2 Accident M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 201 ocompleted cause of death (Item 23a), (Type, Print) ves 300 31. Date filed (Month. Day State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year Jorgensen Maria Cecelia October 8:25PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8100 Connecticut Avenue #810 Chevy Chase <u>Montgomery</u> Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours Min. Director 055-20-1035 1 □ M 2 🏻 F Dec. 10, 1927 84 New York Usual Residence of Decedent r than "naturel", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Chevy Chase 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 8100 Connecticut Avenue #810 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 ⅓ Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Education Chemistry Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jennie Vernola Ignacio Vitiello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erika A. Jorgensen/Daughter 5108 Marlyn Drive, Bethesda, Maryland 20816 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 🗆 Burial 2 🔀 Cremation 3 🗖 Removal from State Bethesda, Maryland Montgomery Crematorium Inc.Oct. 5, 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy C 7557 Wisconsin Avenue, Bethesda, Maryland 20814--M01662 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Diabetes Mellitus Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed Dyslipidaemia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 24 hours after death.
5 Funeral Director: After this certifical letely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman R. Tuli, M.D. 10810 Darnestown Road #202 Gaithersburg, Maryland 20878

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

OCT 0 5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17518 Permanyland 934 12/14/2012 III and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2 2012 Year Elizabeth Park Jenny 0230 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 0230 Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month Day, Year) pr 13, 1924 Director Georgia 252-34-1694 1 □ M 2 🔯 F 88 Apr Usual Residence of Decedent 0/1/01 r then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12263 St. James Road 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 √ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Manasseh Benjamin Park M pe Suzy Hattie Elizabeth Hood Luna Jackson Hood (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Dronenburg/daughter 202 W. Patrick St. Frederick, MD 21701 Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1
Department of I
Important: If it
any injury or of 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 10/05/12 Woodbine, MD 4 Donation 5 Other (Specify) 3. Name and Address of Facility Sing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Examiner holedocholithiasis Sequentially list conditions, if any, leading to immediate cases. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or injury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran oneumonia Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Hospital or Attending Physiclan: 724 hours after death. completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation **Director:** 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0064502 October a 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20850 9901 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State
Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) <sup>ay</sup> 2012 October 8:15 PM Physician/ Lea Juusela Kaija Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Kensington 10215 Greenfield Street 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Sept 1, Hours Year) 929 Finland **Director** 1 □ M 2 😾 F 83 213-40-8982 Yrs Usual Residence of Dece 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 XNo Kensington MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 20895 10215 Greenfield Street 13. Was Decedent of Hispanic Origin? (Specify Yes or Nofiled within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify. 3 → Widowed 4 □ Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Entertainment Opera Singer 5+ Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) h and Mental F t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked or (unk) ည (unk) Naakka (unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25 Johnson Street West Roxbury, MA 02132 Kari Juusela/son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 10/05/12 Woodbine, MD 4 Donation 5 Other (Specify) permit. Going Homes Cremation Service P.O. Box 784 21. Signature of Funeral Service Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cortico-Basal Ganglionic Degeneration vears disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Dementia Sequentially list conditions, if any, eacing to in mediate cause. Enter Underlying Cause (Disease or injury Examiner Due to lor as a consequence of ed by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Year in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Pregnant at time of death 1 Yes 2 Unknown Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospita 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: After X Natural 5 Pending death. Accident ours after death eral Director: A filled in by the f Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse ractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

15 v

(Check only one

29b. Signature and tit

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3720 Farragut Ave. Kensington, MD 20895 M.D. Barry N. Rosenbaum,

31. Date filed (Month

Registrar

29c. License number

D09834

29d. Date signed (Month, Day, Year)

October 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** FLETCHER 9 AM ANE JOHNSON Octobe 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HARBOR HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F Director 224**-**44**-**9783 04-01-37 NC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it. Wedled Emminer must be notified any Injury or other traumatic event, it. Wedled Emminer must be notified a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 863 Bethune Road 21225 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No þ Specify: American 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Care Giver 12th Grade 2yrs Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pernell Steward Mollie Jordan ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Steward-Daughter 863 Bethune Road Baltimore, Maryland 21225 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 10-09-12 Lansdowne, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complete ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final **Physician** Septic shock with multiongon failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner liver Failure Tulminent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) pital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the tuneral director, age 2 should be detached for use as the burish-transit llom2 obstruction bowel resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Division of Vital Records.

To the Hospital within 24 hours a To the Funeral C

29a. Certifier

29b. Signature and title of certifier

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kulasegaram South 3001 31. Date filed (Mo

I kandalay

05

and manner stated.

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

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angston Jones		State of Maryland / Departme	ent of Health and Mental H ate of Death	lygiene	2012	3206
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		_	Eoreig	hplace (State or
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ral",	by F	Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify: VF/	
hour.	ted		ecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use ret		6b, Kind of Business/li	ndustry
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5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)		First Middle, Ma	iden Surname)	
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sh e event, the Medical Examiner must be notified at once	Be	ank	ROSA	VAVER	2	
should and Me 7 is ma natic co	ဥ	1.0	Mailing Address (Street and Number or	Rural Route Number	er, City or Town, State,	Zip Code) 3087
e, MD I and 2 she Health and Fitem 27 is		20a, Method of Disposition 20b. Place of	Disposition (Name of cemetery,	Date 2	20c, Location - City or	Town State
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Balt permit Depart Impor		21. Significate of Full Brial Bell VI Charles	College P. Man 14 f	INTERNA	WE TA	NO 01229
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the de	Physi	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
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tal Rec		25. Was case referred to medical	26.Place of Death (Check		No 1 ✓ Yes	2 No
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ding Phy.		27. Manner of Death 28a. Date of Injury 28b. Ti	me of Injury 28c. Injury at Work?	28d. Describe hov	w injury occurred	
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Division pital or Attendit ours after death.	Certification	Suicide Could not be	m, street, factory, office building, etc.	28f. Location (Street or Town, State	eet and Number or Rur e)	al Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	edical	(Check only 2  Medical Examiner: On the best of my knowledge, death one) 2  Medical Examiner: On the basis of examination and/or inv				
To witi	Med	and manner stated.  29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mon	th, Day, Year)
		( MAR G. BAND	O.C.M.E.	8	September 28, 20	12
2	ŀ	30_Name and address of person who completed cause of death (Item 23a)				
/		Laron Locke MD. Assistant Medical Examiner 900 \	V. Baltimore Street, Baltimore, I	MD 21223		
Sta Regist	ate	31. Date filed (Month, Car Year) 2012 32. registrar's Signature	Barles			
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8: 30 P.M WANDA B. KACPURA 012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARBOR HOSPITAL ALTIMORE MEDSTAR If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 216-36-1810 76 **Director** 1 □ M 2 🏻 F 10/31/36 MD Usual Residence of Decedent 28a-f show 10b. Count ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore XX Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1439 Lowman Street 21230 filed within 72 hours after death with USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 1 Never Married 2 Married 0 þ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Disabled N/A 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bronislaw J. Kacpura pe Bronislawa Wojcicka Page 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Roberts /Sister 1439 Lowman St., Baltimore MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Cremation Center of MD 9/29/2012 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

AD Immediate Cause (Final Immediate Cau Immediate Cause (Final Onset and Death Physician/ PONTINE (EREBROVAS CULAR disease or condition Medical resulting in death) 10 days **Examiner** DNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine nding physician and use as the burial-transit Division of Vital Records, P.O. Box 6876000 Due to (or as a consequence of): resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SYSTOLIC EF 271 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No A. Fib C R. V-R. 24a Was an this certificate has ral director, page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🛛 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) P. Cofffmi Nerrage MD. (HOSPITAUST) Sept 28 70674 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAKSHMI: N. POTAKAMURI, MD. 3001 S. HAWOVER STREET, Baltimore, mp - 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 0 5 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 29, Physician/ 2012 5:00 A M Charles Joseph King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. Director 212-40-6171 1 XM 2 - F Dec. 30, 1941 Maryland 70 Usual Residence of Dec 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 23a or 28a-f |Maryland| Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2317 Philadelphia Road 21040 "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Yes 2 XNo If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane, once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Postal Service Branch Manager Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မ Margaret Rosalie Greene Charles Leo King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2317 Philadelphia Road, Edgewood, MD 21040 Joan B. Kina / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Francis de Sales 10-2-2012 Abingdon, Maryland 4 ☐ Donation 5 ☐ Other (Specify) f Fungful Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus otic Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Cardiamyopa Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA |유 within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Checepeake Dr Belair, md 21614 Desai MD Dav. Year) Date filed (Month. State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 6:25 PM Deborah Lynn Kirby 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director 213-76-3829 1 🗆 M 2 🔀 F 52 Oct. 23, 1959 Maryland Usual Residence of Deced 10a. State 10b. County the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🔀 No Maryland Harford Joppa ö 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? items 23a or ner must be r Funeral 4 Gunpowder Drive 21085 USA within 72 hours after death "natural", or iten ledical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Divorced 4 Divorced Specify: Completed White Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Medical Billing Healthcare and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arch (nmn) Wright Sr. Patricia Ann Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 4 Gunpowder Drive, Joppa, MD 21085 Department of Health Important: If item 27 any injury or other tr Bradd Kirby (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 10-5-12 Baltimore, Maryland permit. 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingo 21. Signature of Funeral Service Licenses teff ander Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ and-stage heart disease disease or condition Medical resulting in death) Examiner mapertension pulmonavu Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami hypoventilation that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 attending physiciar Physician/Medical requires that the death certificate be Kidney Box 68760 use as the yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year detached the signed by d be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ liver disease End-stage 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performed? Yes 2 X No Hospital or Attending Physician: The 1 🔲 Yes 2 🗌 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work?
1 Yes 2 No death. 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. I Division of Vital Records,

> State Registrar

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Within To the

Medical

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29a. Certifier

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29b. Signatur a

only one

31. Date filed (Month, Day, Year)

determined

M.D.

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) Type, Print) all Hospital, 201 E. University Pk Chiagozie Ononiwu, mb. Union Memorial Hospital, 201 E. University Pk Department of Medicine, suite 405 33 4 St.

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AT 2438 946

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

October

29d. Date signed (Month, Day, Year)

Pkwy; Baltimore, Ms

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Michael October 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F Days Hours Yrs Maryland 215-84-9239 48 November 3,1963 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Dundalk 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? ò r items 23a or ner must be n 1954 Guy Way 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò Specify: White 1 Yes 2 No Specify. þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Medical (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 years Technician Haz-Mat 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked or traumatic ever Ferdinand Kresment Jr. Margaret McMahon Lampkin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If item 27 Is or other tra 1954 Guy Way, Dundalk, Maryland Judith Kresment wife 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State October 8 permit. Page Department of Important: If any Injury or once. Bayview Crematory Other (Specify) 4 Donation 2012 Baltimore, Maryland 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due V (or as a consequence of **Physician** 30 minutes disease or condition resulting in death) /Medical **Examiner** DEGROUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Yes 2 No 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 X Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1'☑ Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No eral Director: Al filled in by the fu death. 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a

To the Funeral D

completely filled 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pragner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 2012 12ES-00

DV

State Registrar

30. Name and addre

OCT 0 5 2012

person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14:34 Robert F Keeney Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) 219-36-1918 Director 1 X M 2 🗆 F 72 Feb 22, 1940 MD Usual Residence of Dece show ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 308 West Cherry Hill Court 21136 items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, the Medical Examiner Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Heavy Equipment Operator #2 State Highway Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LaMar Marietta Wise Keeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 West Cherry Hill Court, <u>Barbara Keeney</u> Wife Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/29/12 Carroll Cremation Hampstead, MD 21. Signature of Fineral Service Licensee 11824 Reisterstown Road 22. Name and Address of Facility wer LINS Reisterstown, MD Eline Funeral Home 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Hemurrhage Immediate Cause (Final Onset and Death Intracrania Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** non bow to Denia Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine burial-transi Mycloid Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) ending physician r use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 5  $\square$  Pending iniury 1 Natural work?
1 Yes To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nume Productionar: To the basis of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nume Productionar: To the basis of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nume Productionar: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29d , Date signed (Month, Day, Year) 9 | 27 | 20 1 2 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. W. WANG 22 South Greene Street Baltimore, MO 21201

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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1	Funeral		5. Social Security No			e (In yrs. la	st birthda	y) If Unc	der 1 Year	If Under 24 H	Irs. 8. Date of	Birth		9. Birthp	place (State or I try) Land	oreign
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$\mathcal{Z}_{\mathcal{Z}}^{\mathcal{Z}}$	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	اھا	1 X Never Marri 3 ☐ Widowed		Armed Forces?  d 1  Yes 2  If Yes, Give Year or Dates.	No			ecify Cuba 2 <b>X</b> No		erto Hican, etc.)		Black, Specify:	White, 6		
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12012 Maryland 2121	permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", a many injury or other traumatic event, the Medical Exam once.		Elementary/Second 12	onday (0-12)	College (1-4 or 5	5+)	Se	nior	Scien Chemi	itist <del>s</del> t		J.	M. H	uber	Corp.	
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_ u	_ 89 <b>F # 9</b>		22a Port 1 Enter t	he disease or or	omplications that caused	the death					l - King		le, Ma	ryla T	Approximate	087
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000	ath certificate be attending physic for use as the bu	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	of <u>pr</u> egna	ncy						23d. Date	of deliv	erv	
3	Attending Physician: The law requires that the death certificate be ar death.  setor: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the br	Physician/Medical	in the past 12 1 1 1 Yes 2 1 9 Unknown	months?	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			3		ЭУ ————————————————————————————————————		_	Mont	1	Day Ye	ar
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A is	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no	ot be 28e. Place of Inj			M street, fact		Yes 2 ☐ No	28f. Location			or Rurai	l Route Numbe	r,
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7	vith to the common of the comm		29b. Signature and	title of certifier	ATTENE	1109	44	2	29c. License	e number	9	29d. I	Date signed (	Month,	Day, Year)	'a'
			30. Name and addr	ess of person wi	ho dompleted cause of	death (Item	23 <i>a</i> ) (Typ	e, Print)	MAW	NAING	1. 00 ,	MD	DOCK		091	<u> </u>
	10		31 Date filed /h/cm	h Day Voorl	ho dompleted cause of c	ORD Signa	Mi	MOR	IAZ	405P17	AL, E	AVRE	e De	GR	ACZ.	
	Sta Registr	ite ar	O Date filed (IVIONE	CT 0 5 2	012 Line	ai s sigria		arked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year October Madeline A. Leitch 2:53.P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Davs Hours 218-18-7727 **Director** 1 🗆 M 2 🕱 F 93 Jan. 20, 1919 Maryland Usual Residence of Decede 28a-f show 10c. City, Town or Location at 10a. State 10b. County Director notified 1 🗌 Yes 2 🏻 No MD Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Examiner must be items 23a Funeral 5305 Dulaney Valley Road 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No 0 þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 XWidowed 4 Divorced Completed of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4 or 5+) Credit Union Branch Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Neal C. Hasson Emma Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is, any injury or are 3107 West Colorado Avenue #287; Colorado Springs, CO e of Disposition (Name of Date 20c. Location - City or Town, State 80904 David Tresselt Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 10/6/2012 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses ms 10 MD1050 Hack 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between O t an Death Immediate Cause (Final Physician/ days disease or condition resulting in death) Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying sician and burial-transit Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 OCTOBER IF FEMALE: signed by the attendin d be detached for use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ⊡ ਸਵਾਬਾ ਪਦਕ ☐ Pregnant at time of death in the past 12 months?
1 Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy has LEITCHTo the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) MADELINE28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5  $\square$  Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Under Institute Control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUSTINE PREIS, CRNP

31. Date filed (Month, Day, Year)

12-04841

oshua Lee	1	- For State	State	e of Maryland		artment ( <i>rtificate</i> (			Menta	al Hygiene	Pog Ne	20	12 3207
Physician		<b>Registrar</b> 1. Decedent's Name	(First, Middle,La	Joshua C			-Wing			2, Date of D	Reg. No eath Day		3. Time of Death
Medical Examine	ì.	Joshua				1	ee-			June 28	, 2012		0720 hrs
		4a. Facility Name (if Shady Grove		ive street and number) lospital			4b. City, Rock		ocation of			tc. County of Dea Montgomery	,
Funeral Director	4	5. Social Security No.		Sex 7. Ag	e (In yrs. I	ast birthday)	If Und Month	ns Days	If Under Hours	Min	8irth (Mr 4-20	Fore	Birthplace (State or eign Country) Maryland
<b>&gt;</b> >	- 1-	Usual Residence of			10c City	Town or Loc	eation						10d. Inside City Limits
d cow any		MD	Montgor	nery		mantov							1 Yes 2 X No
the Maryland a or 28a-f show tified at once.	<u> </u>	10e. Street and Nun					10f. Zip	o Code	_		10g. C	itizen of What Co	ountry?
with the Maryland ns 23a or 28a-f sho be notified at once		20438 Su	nbright	Lane			208	374			Un	ited Sta	
hours after death with the Maryland tratural, or items 23a or 28a-f shu Examiner must be notified at once bod by Ermoral Director	nuera	11. Marital Status 1 X Never Marrie		1 Yes 2			f Yes, speci	ify Cuban,	Mexican, F	n? ( Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am White, etc. Specify: As	
s after real", onincer	3	3 Widowed		or Dates: or Dates:	nleted)	16a Deced		X No		nd of work done	16b	Specify: As	
7 , 1		Elementary/Second		College (1-4 or			most of wo						
vithin 7		None				No	ne	<del></del>				None	
37 E H - 31		17. Father's Name (		st)						Name (First, Midd ten Ko	e, Maide	en Surname)	
2121 ould be fi d Mental s marked tic event,	o 🗀	Isaac Ka 19a. Informant's Nai		(Type, Print)		1.0		s (Street	and Numb	er or Rural Route I			
MD d 2 shot lith and n 27 is numatic	Т			- Father	Look	2043 Place of Disp				ne, Germ		wn, Mary	yland 20874
or Heal		20a. Method of Disp 1 Burial 2 🎗	_	Removal from St	ate	crematory or	other place	9)	1				,
Baltimore, ME permit Pages I and 2 s Department of Health a. Important: If iten 27 injury or other traum	ŀ	4 Donation 5	Other Specif			itional	L Cres					ky-Gold	urch,Virginia hero
Balti permit. Departm Imports	1	5000	ent	Edward	_		1170	Rockv	ille	Pike, Ro	ckvi	.11e, Ma	ryland 20852
Physician	1		e disease, or con y one cause on	nplications that caused each line.	the death	. Do not ente	r the mode	of dying, s	such as car	diac or respiratory	arrest, s	hock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (For condition resulting		Positiona Due to (or as a cons							_		Death
		Sequentially list cor		b.	equence (	л). 							
		if any, leading to im cause. Enter Unde	mediate	Due to (or as a cons	equence o	of):							
_ :	E	Disease or injury if events resulting in o		Due to (or as a cons	equence o	of):							
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ate be e		IF FEMALE:		#I,per me	ne of preg	32 10-2 gnancy	2 <u>2–12</u>	SIII			12	23d. Date of deliv	ery
tox 6876 eath certificate at the displaying phy for use as the line.		23b. Was decedent past 12 months		1 Live birth  Pregnant at	time of de	2 = eath 5	Fetal death		Ect <b>o</b> pic	pregnancy		Month	Day Year
Box 6876 e death certificate the attending phy ed for use as the	Physician	1 Yes 2 N	lo 9 Unknov			5	Other (Spe	есту)					
P.O.	6	Part II. Other signif	icant conditions	s contributing to deat	n but not i	resulting in th	e underlyin	g cause gi	ven in Par				to the cause of death?
w requires to been so should to	Completed									24a. W	as an		autopsy findings available completion of cause of
Reco	E										erformed es 2		
Vital Recc ysician: The lav his certificate ha director, page 2		25. Was case referr	ed to medical	Hospital: 1 Inpatie		3				Check only one)  Nursing Home 5			
Physic er this	의		2 No	28a. Date of Inju	irv	ER/Outpation 28b. Time			at Work?			njury occurred	ner:
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ivisior or Atteno after death Director:	Certification:	2 X Accident 3 Suicide	Investiga 6 Could no	28e. Place of Ir	ijury - At h	nome, farm, s	treet, factor	y, office bu	uilding, etc	. 28f. Locatio	n (Stree n, State)	t and Number or 20438 St	Rural Route Number, City Inbright Ln.
Spital hours a neral 1	5	4 Homicide 29a. Certifier	determir	(0)11)/		Reside	-			German	1tow	n,MD.	
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical	(Check only 1 one) 2	Certifying Phys Medical Examir	ician: To the best of m	y knowled mination	age, death oc and/or investi	curred at th gation, in m	ie time, da ny opinion,	death occ	e, and due to the durred at the time, d	ause(s) ate and	and manner as s place, and due to	the cause(s)
O Parity Pro	Ž	29b. Signature and		and manner stated			29	c. License	number				Month, Day, Year)
n l		h	i au	- /				O.C.N	И.Е. ———		Ju	ine 29, 2012	
Kperd		30. Name and addr	ess of person wh	o completed cause of o	leath (Iter	n 23a) W. Baltim	nore Stre	et, Balti	more. M	ID 21223			
Sta	te	31. Date filed (Mo	~ -		r's Signat	A 7.4	ever						
Registr	ŭ		UI U 5 2	UL Cheen	U,	3. A.	The						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 3, Day 2012 Year Lillian Anna Long 3:40AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 423 Twinbrook Parkway Montgomery Rockville If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 216-40-7084 Director 1 🗆 M 2 🗶 F 83 1929 June 17, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland el Hygiene. d other then "netural", or items 23a or 28e-f show event, the Medical Examiner must be notified at. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 United States 423 Twinbrook Parkway 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Analyst U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) i. Page 1 end 2 should be filed tment of Health and Mentel H tent: If item 27 is marked ot jury or other treumetic ever Mary Pijanowski Anthony Ramagnano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20837 John P. Long/Son 5 Hillard Court, Poolesville, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 e Department of H Importent: If ite eny Injury or ot 20c. Location - City or Town, State October 5, 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 4 Donation 5 Other (Specify) 2012 Brentwood, Maryland Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 Miller skuly -M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Gastrointestinal Bleeding Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Renal Failure Sequentially list conditions, if any least the state of the cause. Enter Underlying Examine Due to for as a consequence of use as the burial-transit Hospitel or Attending Physician: The lew requires thet the death certificete be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician the dorse Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year detached 9 Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 8 1 Yes 2 No 3 Probably 4 Unknown To the Hospitel or Attending Physician: The lew require within 42 hours after death.

To the Funerel Director After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\stackrel{K}{\square}$  Residence 6  $\square$  Other (Specify) Hospital: 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of pay knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35103 October 4, 2012 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 6240 Montrose Road, Rockville, Maryland Stephen G. Vaccarezza, M.D. 20852 31. Date filed (Month, Day, Year) 0CT 0 5 2012 State 2. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 30 per dyr 9932 10-5-12 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:30 AM David Marshall, L. Physician Sr. september 30 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Centers, Social Security Number 6. Sec 7. Age (In yrs. last birthday) Anne Arundel 6len 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year, 1/25/54 5. Social Security Number **Funeral** Months Days Min. 1 **∑**M 2□ F 215-62-2971 58 MD **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b, County and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinar must be molified at 28a-f show 1 ☐Yes 2 No MD Anne Arundel Pasadena Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8469 Byrd Road 21122 USA by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐Yes **¾X**No Specify: White 1 □Yes 2 XXXIo If Yes, Give Year or Dates: Specify: 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Food Processing Meat Cutter 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be I and 2 should be fi Health and Mental H permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ew once. Stanford A. Marshall, Sr. Mary Eader ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marshall /Son Brian K. 718 205th Street, Pasadena Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cremation Center of MD 10/3/2012 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service Licensee Victor P. Doda 0123° 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiogenic Shock Physician /Medical Due to (or as a consequence of): Acute my ocerdial Infarction Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 MNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28b Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed 24 brows after of death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, bane 2 should be death. P.O. Box 687605 Division of Vital Records,

Baltimore, Maryland 21215-0036

Marshall Davi

within 24 hours a
To the Funeral C

State Registrar

Medical

29a, Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ell

and manner stated.

1417 Madison Park Dr. Glen Burnie, Md.

DHMH 17 Rev 1/2001

7

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D6141

29d. Date signed (Month, Day, Year)

			Pleas	nd #19a, per INE e Type of Print in E AMEND ITEM#22 State of Maryland i #8 per FH G941	g <b>932</b> lack li per FH	10-11-12 ndelible in ,G932,10	k. <b>Ensure A</b> 7572012 W	VII Copies	s Are Leg	gible.	
		-	For State Amen	i #8 per FH G941	77117 Ce	<b>713 TRT</b> <i>Tificate of L</i>	neaith and is Death	лента пу	Ben No 2	012	32078
			Registrar  1. Decedent's Name (First, Middle, L					2. Date of Dea		Voor	3. Time of Death
	Physicia Medic		AVERY	MILES		1		SEPTEM	IBER 24	2012	9:58 P <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, gi 8801 ORBIT LA			4b. City, Town, or GREEN	RELT		4c. Count	y of Death CE GEOI	RGE"S
•	Funeral Director			Sex , 12 M 2 G F 7. Age (In vrs. le	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 12/22/	h Line	T	ace (State or Foreign
4	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.  The strain and Mental Hyglene.  The strain arked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Lo	cation	1			10	d. Inside City Limits
	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	Director	10e. Street and Number	10 2	17/1	10f. Zip Code	/	— Т	10g. Citizen of	What Countr	1 Nes 2 No
	with the 23a cast be	Funeral	8801 ORBI	+ LANE		2	0704		l	115A	
	death items		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?			lispanic Origin? (Sp an, Mexican, Puerto			ce - America ack, White, et	
036	s after ral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 No	Specify:		Specif	1. BLI	4CK
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	filed w al Hyg d othe	o Be	17. Father's Name (First, Middle, Las		100	· ·	18. Mother's Nam	ne (First, Middle,	Maiden Surnan	ne)	
Maryland	should be file and Mental F 7 is marked o raumatic eve	မ	19a. Informant's Name/Relationship	6 MI		A dalaana (Ohrank	and Number or Run	12//VZ	r City or Town	State Zin Co	- L L
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Baltimore,	ge 1 and nt of Heal : If item or other		20a. Method of Disposition  1  Burial 2  Cremation 3		emetery, crei	osition (Name of matory or other place	ce) !	Date	20c. Location	- City or Tov	vn, State
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Ba	permit. Pag Departmer Important any injury once.		21. Signature of Fee I Service Lice	But	Hố	vell Fun	ërai Home	10220	Cuilfo	rd Rd	Tessup 1
7	Physician/ Medical Examiner	19	23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	and cause on each line	lero		est es				Approximate Interval Between Onset and Death
b	ecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or to a consequence.	anos ciji						
09/	ate be exec physician ar the burial-tr		resulting in death) Last	Due to (or as a consequent d.	ence of):						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d g ☐ Unknown	Ideath 3	☐ Ectopic pregnan☐ Other (specify) _	cy			ate of delive	ry Day Year
<u>0</u>	iires that the dea signed by the a Id be detached f	by Pt	Part II. Other significant condition								e cause of death?
rds,	equires een sig ould b	ted	Prain M	severysme o	W	302					ably 4 Onknown
SCO	sician: The law require certificate has been si rector, page 2 should	mple						24a. Was auto perfe		prior to con death?	sy findings available npletion of cause of
Ä	in: The	Be Co	25. Was case referred to medical			26. F	Place of Death (Chec		2K No	1 Yes	2 L No
Zita Zita	Physicia this cert al direct	To B	examiner? 1X Yes 2 No	Hospital: 1  Inpatient 2	ER/Outpatie	nt 3 🗆 DOA Oth	ner: 4  Nursing H	ome 5 🔀 Resi	dence 6 🗆 Ot	ther (Specify)	
J of	Jing Pl J. After th funera	ate:	27. Manner of Death  1 Natural 5 Pending	(Month, Day, Year)	28b. Time o injury	wor		28d. Describe	how injury occu	rred	
Division of Vital Records,	Hospital or Attendi 24 hours after death. Funeral Director. A eted filled in by the fo	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 280 Place of Injury - At ho				28f. Location ( City or Tox	Street and Num wn, State)	ber or Rural	Route Number,
	To the Hospital or Attending Physician: The k within 24 hours after death.  To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Medical	(Check 2 Medical Fy	hysician: To the best of my knowle aminer: On the basis of examination lurse Practioner: To the best of my	and/or inve	stigation, in my opin	ion, death occurred a	at the time, date	and place, and c	lue to the cau	se(s) and manner stated
	To the within 5 To the comple	_	29b. Signature and title of certifier			200 Licens	e number		20d Date sign	od Month F	lav Vear)
	^		fredva.	an / y or	2201/15	Drint)	10737		sepl h	use	16 0012
	10		30. Name and address of person will Sall Valor - 31. Date filed (Month, Day, Year)	no completed cause of death (Item	ZJa) (Type,	espital	Ding	Chel	rely,	MA.	yland_
	Sta Registr		OCT O 5 2012	oz. negistrar s digital	backer	1	,				

		An	Please nend #1 per mD g932	Type or Print in B 10/5/12 trt State of Maryland	lack Indelible In	k. Ensure A	II Copie	s Are Leg	ible.
			For State Registrar	Otate of Marylane	Certificate of L	Death	ionai i iy	Reg. No. 2	012 3207
	Physicia Medi		Decedent's Name (First, Middle, Last)	MELRA	Mary Murph		2. Date of De	-	3. Time of Death 8:32a M
	Examir		4a. Facility Name (if not institution, give s	RLE TE	RRACE	r Location of Death  BSB  If Under 24 Hrs.	2 8. Date of Bir	4c. County	
	Funeral Director		218-48-1939 Usual Residence of Decedent	1м 2 Й г 65	Yrs. Months Days	Hours Min.	(Month, Da		g. Birthplace (State or Foreign Country) Kentucky
	e Maryland r 28e-f sho notffed m	Funeral Director	10a. State 10b. County 10b. County Baltimo		Town or Location SSEX				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with th ms 23a o must be	uneral l	808 Runkle Te			1221		10g. Citizen of V	A
5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or items 23a or 28e-f show eny Injury or other treumetic event, the Nector Examiner must be notified at once.	δ	1 🔁 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	Specify:	ecify Yes or No- Rican, etc.)	Specify:	e - American Indian, k, White, etc. White
2121	within 72 ho giene. ner then "na t, "h. M. Ge	Sompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2 t h		16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired) I • T • Speci	during most of worki	ing	ľ	ns Hospital
Maryland	ild be filed Mental Hy larked oth	To Be	17. Father's Name (First, Middle, Last) Victor Smi	th Cm		18. Mother's Name			9)
aryl,	ould b		19a. Informant's Name/Relationship (Typ		19b. Mailing Address (Street		en Hat		itate Zin Code)
	nd 2 sh ealth a m 27 ls		Victor Smith Jr	. /brother	6313 Virgin				
Baltimore,	Page 1 er ment of H ant: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Cer	ce of Disposition (Name of metery, crematory or other plac YView Cremat	ce)	Date 0/12		City or Town, State
Balt	permit. Depart Import eny Inj ence.		21. Sign at re of Funeral Service License	D.	22. Name and Addre	9			Balto. MD f Essex 21221
	cate be executed  Medical Examiner  sthe burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	TENSION nce of): ERYTHM nce of):	g, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between Onset and Death
. Box 68760	ath certifi ettending for use e	Physiclan/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9 Unknown	Bc. If yes, outcome of pregnand 1  Live Birth 2  Fetal of 4  Pregnant at time of de 9  Unknown	death 3 🔲 Ectopic pregnand	cy		23d. Dat Mor	te of delivery nth Day Year
ls, P.O.	requires that the dei been signed by the s should be detached	ed by P	Part II. Other significant conditions con	tributing to death but not resul	ting in the underlying cause giv	ven in Part I.			ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
<b>Řecords</b> ,	The lew req cate has bee pege 2 sho	Completed by	CIGARETTE BIDOLAR	SMOKI DISORDEK	NG 2		24a. Was auto perfo 1 \( \sum \text{Yes}	psy primed? c	Nere autopsy findings available prior to completion of cause of leath?
ita	sician: The certificate irector, peç	Be	25. Was case referred to medical examiner?  1  Yes 2 D No	ospital:	Oth	ace of Death (Check		<del></del>	
of Vital	ding Phys h. After this of funeral dir	e: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ El 28a. Date of injury 2	8b. Time of 28c. Injury	4 ∐ Nursing Ho y at		dence 6 Other	
o	Attendin er death. ector: Aft by the fur	ficat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury work M 1 □	? Yes 2 ☐ No			
Division	vital or Atte urs after de ral Director illed in by th	al Certificate:	4 Homicide determined	building, etc. (Specify)	e, farm, street, factory, office		City or Tox	vn, State)	er or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b	Medical (	(Check 2 Medical Examine only one) 3 Certifying Nurse	cian: To the best of my knowled er: On the basis of examination a Practitioner: To the best of my	and/or investigation, in my opinio	on, death occurred at	the time, date a	and place, and due	to the cause(s) and manner stated
	5 4 × 4		29b. Signature and title of certifier		29c. License	number		29d. Date signed	(Month, Day, Year)
			30. Name and address of person who co	mpleted cause of death (Item 2	(Type, Print)	000000	١	110	7/2
_			AYAZ HAROON,	MD 1245 1	EASTERN B	CUD, E	SSFYL	ND	2/02/
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	back				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 32080

Heather Dawn Mar	1	- For State	State of	Maryland		artment of rtificate of			Mental H		Reg. No.	20	12 320
Physician Medical Examine	1	1. Decedent's Name	(First, Middle,Last)	wn Mart	in					2. Date of De Month October		Year 2	3. Time of Death 1144 hrs
	4		not institution, give st el Road & Single		)		4b. City, To Parkto		ocation of Dear	th		altimore Co	
Funeral Director	,	5. Social Security Nu	L	7. Ag	e (In yrs. I 25	ast birthday) Yrs	If Under		If Under 24Hr Hours Mi			/DD/YYYY) 9. Bi	rthplace (State or gn puntry) MD
any	-	213-25 Usual Residence of D 10a. State	$\mathbf{x}_{0}$		10c, City,	Town or Locat							10d. Inside City Limits
	<u> </u>	MD	Carro	11		Hamps	tead						1 Yes 2 X No
with the Maryland ns 23a nr 28a-f shnw he notified at once. aral Director		10e. Street and Numb 19727	7 Grave 1	Run Roa	ıd		10f. Zip (	210	74		-	zen of What Cou USA	intry?
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Figure. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f sho injury nr other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1	11. Marital Status 1 S Never Married	d 2 Married 1			If Y	es, specify	Cuban, N	Mexican, Puert	Specify Yes or N o Rican, etc.)	0-	White, etc.	rican Indian, Black, nite
hours afte natural" Examine	2 -		4 Divorced If or ucation (Specify only b	Dates: nighest grade cor		16a. Deceden		Occupation	speary: n (Give kind of O NOT use re			Specify: Will Kind of Business/ NSWeril	Industry
5-0036 led within 72 hours after the within 72 hours after the water after the wither the with the Medical Examine Completed by		Elementary/Second		College (1-4 or	5+)	-	erat	or		311.	S	ervice	
21215-0036 uld be filed within 7 Mental Hygiene. marked inther than c event, the Medica	3	17. Father's Name (F Thomas	First, Middle, Last)  S Martin					18		e (First, Middle, velyn			
MD 21 d 2 should lth and Me n 27 is ma numatic ev	2 1		ne/Relationship (Type Cheek /		ther							ity or Town, State sville	e, Zip Code) MD 21228
nore,   ges l and at of Heali i: If item other tra			Cremation 3	Removal from St	20b. i	Place of Dispos crematory or oth DLLY H.	ition (Name ter place) Î. I. I. (	e of ceme Ceme	tery,	Date 10/06/	20c. 1	Location - City or Baltir	Town, State
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra	2	4 Donayon 5 21. Signayor e of Fune	Other Specify: eral Service Incresee	Da.		22. N	ame and A	Address of	Facility 3	00 Mac	e A	ve. Ba	lto. MD
Physician	2		disease, or complica one cause on each		the death.								Approximate Interval Between Onset and
Examiner		mmediate Cause (Fin or condition resulting		Iltiple Blunt F to (or as a cons									Death
), be executed ician and urtal - transit	i (	Sequentially list cond f any, leading to imm cause. Enter Underly Disease or injury tha	nediate Due ying Cause at initiated	to (or as a conse									
0, be executed rsician and burial - transit		events resulting in de	d		equence of								
		UNPENDED		MENDED 23c. If yes, outcor	ne of pregr	nancy					230	d. Date of deliver	y
). Box 6876( the death certificate by the attending physiched for use as the b Physician/Me	1	3b. Was decedent propast 12 months?  1 Yes 2 No		Live birth Pregnant at Unknown	time of de	ath	al death ner <i>(Speci</i> i		Ectopic pregn	ancy		Month E	Day Year
s, P.O. uires that the uires that the n signed by id be detach		Part il. Other signific	cant conditions co	ntributing to deat	n but not re	esulting in the u	nderlying o	cause give	en in Part 1.	1 Ye	s 2 🗸	No 3 Prob	the cause of death?  pably 4 Unknown
Division of Vital Records, P.O. Boy tal or Attending Physician: The law requires that the death as after death.  *I Director: After this certificate has been signed by the att led in by the funeral director, page 2 should be detached for errification: To Be Completed by Physis				-						1 ✔ Yes	psy orm <u>ed</u> ?	prior to death?	topsy findings available completion of cause of
Vital hysician: hysician: this certi		<ol> <li>Was case referred examiner?</li> <li>1 ✓ Yes 2</li> </ol>	Hosp	oital: 1 Inpatie	nt 2	ER/Outpatient			Death (Check		Reside	nce 6 🗸 Other	r: Scene
		7. Manner of Death  1 Natural  2 Accident	5 Pending	28a. Date of Inju Oct 2, 2012	гу ear)	28b. Time of Ir 1133 hrs	· ·	3c. Injury a	at Work?	28d. Describe Driver auto			
Division o  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune fedical Certification:		3 Suicide 4 Homicide	Investigation  6 Could not be determined	28e. Place of In			t, factory, o	office build	ding, etc.	28f. Location ( or Town, S Mount Carme	Street a	nd Number or Ru Singletree Lar	ral Route Number, City
Divi To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Certifi		9a. Certifier 1 Co	ertifying Physician: ledical Examiner:On	the basis of exa						d due to the cau	se(s) an	d manner as state	ed.
To with To com	2	9b. Signature and titl		d manner stated.			1	License n				Date signed (Mo	nth, Day, Year)
.)	3		ss of person whe com		,	,	1	OJC.M.				ober 3, 2012	
State	3	Russell Alexa  1. Date filed (Month,		32. Registra			V. Baltir	more St	treet, Baltin	nore, MD 21	223		
Registra	•	OCT 0 5 2		. 1	Mary	Mand							

OCM:E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Month Physician/ 01Day Jave P. Morgan 2012 9:10A M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner N/A Gilchrist Hospice Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 1 □ M 2 F 11/25/1952 215-60-0332 59 Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified et 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No N/A Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21206 4219 Berger Ave. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) State of MD Federal Investment Agency Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Earlene Satterfied permit. Page 1 and 2 should be f Department of Health and Menta Importent: If item 27 is marked eny injury or other traumatic ev James Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4219 Berger Ave., Baltimore, MD 21206 19a. Informant's Name/Relationship (Type, Print) Ilyana Knight(daughter) Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State on-site Crematory 1008 (17 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat of Funeral Service Licenses 303epHodrs Brown Jr. Funeral Home 21217 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonari Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir or Attending Physicien: The law requires that the death certificate be executed and -transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 pronths?

1 Yes 2 No Month Day To the Hospitel or Attending Physicien: The law requires that the cea within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the a completely filled in by the funeral director; page 2 should be detached? 1 Yes 2/2 9 Unknown a Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, ESR-D 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) WOSP( 4 27. Manner of D ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ND HARVES HAMON 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 1 Kathleen M. McFadden 8:14 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Days **Director** 174-36-6478 1 M 2 XF Dec. 16, 1943 Pennsylvania 68 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Harford Belcamp 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be Funeral 1123 Belcamp Garth 21017 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Yes 2 X No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Supervisor U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever ပ္ Margaret (nmn) Larkin John E. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth McFadden / Daughter 2201 Hunters Chase, Bel Air, MD 21015 Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Removal from State St. Dominic's Cem. 10-8-2012 Philadelphia, PA Donation 5 Other (Specify) of Euneral Service Licens 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and D Physician/ Obstructive disease or condition resulting in death) Medical Due to (or as a consequence of) Mº Fadden, Keth **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): nding physician and use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown m 80061570C 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 2 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Pyes 2 No 1 Natural 5  $\square$  Pending injury ☐ Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) D0056296 10-2-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Dr. Delain; md 21014 Birnown vasn M.

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

1-0/

			For	State of N	Marylan					lental Hy	giene		
			State Registrar	( )		Cer	tificate c	of Deat	h		Reg. No.	2012	3208
	Physicia Medic		Decedent's Name (First, Middle, William	, Last) Philip	Mi	nicozz	i			2. Date of De.		20 jež	3. Time of Death 9:42 P M
-	Examin		4a. Facility Name (if not institution,	give street and number	)		4b. City, Tow				4c. C	ounty of Death	
$\leq$			Holy Cross Hosp					ver S				Montgo	
	Funeral Director		5. Social Security Number  199–28–1656  Usual Residence of Decedent	6. Sex 1 X M 2 □ F	nge (In yrs. Ia 75	ast birthday) Yrs.	If Under 1 Y Months Da	ays Houi	rs Min.	8. Date of Birl (Month, Da 09/18/	y, Year)	Coun	place (State or Foreign htry) nsylvania
	and show at	ō	10a. State 10b. County		10c. City	y, Town or Lo	ation					1	0d. Inside City Limits
	Maryla 18a-f tified	rect	MD Mon	tgomery			Silve:	r Spri	ing				1 ☐ Yes 2 🗶 No
	a or 2 be no	Funeral Director	10e. Street and Number				10f. Zip Co	de			10g. Citize	en of What Cour	ntry?
	h with	ner	12325 New Hamp					20904			Unit	ed Stat	es
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	1 100	t Ever in U.S ? XNo		Vas Decedent f Yes, specify (			cify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: Wh	
5-0	hour "natu dical	plet		nt's Education st grade completed)			lent's Usual Ockind of work do		nost of worki	na	16b. Kind	of Business/In	dustry
2	hin 7% ne. <b>than</b> ie Me	mo	Elementary/Secondary (0-12)	College (1-4 o	r 5+)	life. D	O NOT use reti	ired)	nost or working	ng .	ша	anital/	Daggarah
5	ed with	Be C	17. Father's Name (First, Middle, L.	5+ ast)		<u>Do</u>	ctor	10 M	lathar'a Name	e (First, Middle,			Research
ylan	ild be file Mental I iarked o atic eve	To E	Angelo	,	nicoz	zi			ora	e (First, Middle,		ericola	
Mar	d 2 shou alth and 27 is m r traum		19a. Informant's Name/Relationsh William P. Mi		Son	1	ng Address (Str Common				r, City or To	wn, State, Zip ( <b>78</b>	Code)
Baltimore, Maryland 21215-0036	Page 1 and ment of Hes ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2XXCremation 4 ☐ Donation 5 ☐ Other (S <sub>i</sub>			lace of Dispo	sition (Name o natory or other e Crema	f place)	т —	Date		ation - City or To	
Balt	permit. Departi Import any inji		21. Signature of Funeral Service Li	photos.	00982	22 R 9	Name and Adapp Fur 33 Gist	ddress of Fa neral Ave	acility and Ci	remation	n Ser	vices MD 20	910
navig.	Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition		ne.								Approximate Interval Between Onset and Death WEEKS
1	Medical Examiner		resulting in death)	Due to (or a	s a consequ	ience of):						- 1	WEEKS
7	ed sit	miner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. —	s a consequ	ience of):							WEEKS
3/6	ite be executed hysician and he burial-transit	dical Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	ence of):							
09,	ate be			d									
Box 687	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1  Live Birth 4  Pregnant 9  Unknown	n 2 ☐ Feta at time of d	Ideath 3	Ectopic preg				23	d. Date of delive	ery Day Year
P.O.	that the dea ned by the a detached f		Part II. Other significant conditio	ns contributing to death	but not res	ulting in the u	nderlying caus	e given in P	Part I.	23e. Did to	bacco use	contribute to the	ne cause of death?
S, F	signe d be	d by	CHRONIC K	IDNEY DISEA	SE								pably 4XXUnknown
ord	require been si should	lete	ANEMIA DU	E TO CHRONI	C DIS	EASE				24a. Was	an T	24b. Were autor	psy findings available
of Vital Records,	sician: The law certificate has irector, page 2	Completed								autor perfo		prior to co death? 1 🗌 Yes	mpletion of cause of 2 No
ita	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			T	6. Place of 0	Death (Check	only one)			
0	ding Phys h. After this funeral di	ite: To	1 ☐ Yes 2 💢 No  27. Manner of Death  1XXNatural 5 ☐ Pending	1 X Inpa 28a. Date of in	jury	ER/Outpatier 28b. Time of injury	t 3 □ DOA   28c. I	njury at		me 5 🗌 Resid 28d. Describe h		Other (Specify ccurred	)
ion		ifica	2 Accident Investig 3 Suicide 6 Could	gation				1 🗌 Yes 2	2 🗆 No				
Division	al or Atten s after deat Il Director: ed in by the	Certificate:	4 Homicide determi	28e. Place of I	njury - At ho etc. (Specify)	me, farm, stre )	eet, factory, off	ice	1	28f. Location (S City or Tow		lumber or Rural	Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of Nurse Practitioner: To	examination	and/or invest	igation, in my o	pinion, deat	h occurred at	the time, date a	nd place, ar	nd due to the car	use(s) and manner stated.
	To the within To the COTTA	~	29b. Signature and title of certifier	) . 4-0 =:	,	<u> </u>	29c. Lic	ense numbe	er			signed (Month, I	
			) proy	Mose	_			D3233	32		OCT	OBER 1,	2012
	3		30. Name and address of person SURESH K. GUPT.	•				220, 5	SILVER	SPRING	, MD	20902	
	Stat	е	31. Date filed (Month, Day, Year)			re pa					-		
	Registra	ir	OCT O 5	2012 Below	NB	·							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Ann Merollini 2012 2 9:05PM October 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11200 01d Club Road Rockville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Davs Hours 578-30-4368 Director 1 . M 2 F 85 Jan. 24, 1927 Washington, D.C. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours efter death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11200 Old Club Road 20852 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation permit, Page 1 end 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Treasurer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Louis Facchina Edna Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Merollini/Son 24601 Woodfield School Road, Gaithersburg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 6. 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2012 Silver Spring, Maryland Signature of Funeral Service Licens Robert A. Fumphrey Funeral Home, Rockville, Inc Million M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Medical Due to (or as a consequence of): Examine Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Thoracic Aortic Aneurysm that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant 9 Unknown Month Year Pregnant at time of death 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X N 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nursing Home 6 Nursing Home 5 Nursing Home 6 Nursing Home in 24 hours are:
the Funeral Director: After this calculated in by the funeral directors. ဥ 1 X Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending □ Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) MD0059794 07 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1201 Seven Locks Road #111, Rockville, Maryland Le Le Luu, M.D. 20854 31. Date filed (Month, Day, Year) State Registrar OCT O

			1 _ State		artment of He <i>rtificate of De</i>					
			Registrar  1. Decedent's Name (First, Middle, Last)		Timodic or Bi	Jan	2. Date of Dea		0 + 2	3. Time of Death
	Physici /Medic		Genevieve Elaine McLaughli	ın			Month Octobe	Day	Year	2:00PM
-	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County	y of Death	
-			Sunrise Senior Living		Severna P	Park f Under 24 Hrs.	0.0.1.100		Arund	
E	Funeral Director		5. Social Security Number  469–16–8432  6. Sex 1 □ M 2 ▼ F  7. Age	(In yrs. last birthday) 94 <sup>Yrs.</sup>		Hours Min.	8. Date of Birt (Month, Day Mar 18	, Year)	9. Birthpla Counti Minne	
	ס		Usual Residence of Decedent				Mar 10	, 1910	Pittine	Soca
	show	<u>_</u>	10a. State 10b. County	10c. City, Town or Lo	ocation				10	d. Inside City Limits
	he Ma 28a-f	Director	MD Anne Arundel  10e. Street and Number	Severna F				40 000		1 ☐ Yes 2XX No
	with t	Ξ	41 W. McKinsey Road		10f. Zip Code 21146			10g. Citizen of USA	wnat Counti	ry ?
	death	Funeral	11. Marital Status 12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No-		ce - America	
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show Goal Evending India		1 Never Married 2 Married 1 Yes, Give			Mexican, Puerto i Specify:	rican, etc.)		ck, White, et	
21215-0036	hours tural"	ed by	3 ¼ Widowed 4 □ Divorced Year or Dates:						y Whit	
15	nin 72 n "nai	plet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation  kind of work done duri  DO NOT use retired)	ing most of workir	gg	16b. Kind of B	usiness/inat	istry
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Maryland	be file tal H) d oth event	Be	17. Father's Name (First, Middle, Last)			3. Mother's Name		Maiden Surnar	ne)	
Z	d Men narke	မှ	John H. Dubbels			lva M. I				
<u>⊠</u>	id 2 sh Ith an 27 is r traur		19a. Informant's Name/Relationship (Type. Print)  Gail M. Stephens/daughter		ng Address (Street and Mill Race					Code)
ē,	s 1 an of Hea other		20a. Method of Disposition		osition (Name of matory or other place)		ate	20c. Location		ın, State
altimore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show yor other traumatic event, the "motical Eventual must be notified at		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	· ·	rney Crema	tory 10/	2/12	Woodbir	ne. MD	
alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22	2. Name and Address of Coing Home	of Facility				79.4
<u> </u>	20 <b>2 4 5</b>		/ leli-rig	M01021  B	everly L.	<u>Heckrott</u>	e, P.A.	Clarks	sville	, MD 21029
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	ospita hours unera ily fille		29a. Certifier (Check only 2 Medical Examiner: On the basis of e	my knowledge, deati	h occurred at the time,	date and place, a	and due to the	cause(s) and m	nanner as sta	ated.
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	with cor.	2	29b. Signature and title of certifier		29c. License ni			29d. Date signe		2 c ( 2
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	12		30. Name and address of person who completed cause of dea			Uc rain	ite	<u> </u>		9
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	Registra	ar	UCT 0 5 2012 Denous	U B. A	aven					

Ronald Jerome Mo	1- For State	Stat	e of Maryla		artment o		nd Mental	Hygiene	Reg. No	21	112	320
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re, l 1 and FHealt Fitem	20a. Method of Disp	osition		20b.	Place of Dispos crematory or ot	ition (Name of ce	emetery,	Date		Location - C		
Pages I.	4 Donation 5			Fi	nal Jou	rney Cre	ematory	10/04/12	2 W	oodbir	ne, MI	)
Baltimore, permit. Pages 1 a Department of He Important: If ite	21. Signature of Fun	eral Service Lic	ensee /		22. I	ing Home	s of Facility CRemat	ion Serv	vice	P.O.	Box	784
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	30. Name and address											
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onathon Joseph i	1	nley St - For State	ate of Maryla	ind / Dep		of Health and		Hygiene	Reg. No.	012 3	208
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neardar Examine		JONA ER 4a. Facility Name (if not institution	on, give street and nu			4b. City, Town, or			4c. County	of Death	
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after de	2	3 Widowed 4 Div	/orced If Yes, Give Yea or Dates:	2 <b>X</b> No		Yes 2X No			Specify:	White	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle		- <del></del>			18.Mother's Na	` '	Maiden Surname		
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Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health is marked other than "natural", or items 23a or 28a-fabe injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Buriat 2 K Cremation	n 3 Removal fro	om State	crematory or o	ther place)	and 1	0/1/2012		Hill, MD	
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Physician Medical	1130	23a. Part I. Enter the disease, or failure. List only one cause	on each line.			the mode of dying,	such as cardia	ac or respiratory a	rrest, shock, or he	art Approximate Between On: Death	set and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Intraoral Gu Due to (or as a								
		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):			•			
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876( tificate ng phys as the b	2 Z	IF FEMALE: 3b. Was decedent pregnant in t		outcome of pre irth		etal death 3	Ectopic pre	gnancy	23d. Date of Month	•	ear
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ding Pl		27. Manner of Death 1 Natural 5 Pen	28a. Date (Month Sep 26,	of Injury Day Year) 2012	28b. Time of 1845 hrs		ryat Work? Yes 2 ✔ No	28d. Describe Subject sh	e how injury occur ot self	red	
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Div	Certification:	4 Homicide	ermined (Specify)		mily Home				Mill Road, Ham		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ल्	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	Physician: To the bes	at of my knowle of examination	edge, death occu and/or investiga	urred at the time, da ation, in my opinion	ate and place, n, death occurre	and due to the ca ed at the time, dat	use(s) and manne te and place, and o	r as stated. due to the cause(s)	
To with To com	Wed-	29b Signature and title of certifi	and manner s er	tated.		29c. Licens	e number		29d. Date sign	ned (Month, Day, Year)	
	Y	I am look	dup			O.C.	M.E.		Septembe	r 28, 2012	
<b>)</b>		30. Name and address of person Laron Locke MD.	n who completed caus Assistant Medica			Baltimore Stree	et, Baltimore	e, MD 21223			
Sta		31. Date filed (Month, Day, Year)		egistrar's Signa	iture						
Registr	_	OCT 0 5	2012 Jan	ma p		Kel					
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 02, Beverly Law McElhose 2012 4:15 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore County Timonium Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months Hours 213-28-8090 **Director** 80 1 🗆 M 2 🛣 F Endicott, N.Y. July 04,1932 28a-f show aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Baltimore County White Marsh 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 11028 Bird River Grove Road 21162 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ♣ No Black, White, etc. 0 ģ 1 Never Married 2 Married 1 Yes : Maryland 21215-0036 1 Yes 2 X No Specify: "natural", White Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Payroll Clerk marked other Penco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Lloyd G. Law Margaret V. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Mrs.Rebecca Rose Mohr (Daughter) 11028 Bird River Grove Road White Marsh, MD. 21162 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 ★ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Thursda Moreland Memorial Park 4 Donation 5 Other (Specify) Baltimore, Maryland Oct. 4, 2012 see Jeffrey L. Gair, SR. O.S. Peaceful Alternatives Funeral and Cremetion Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 Part . Enter the disease shock, or heart failure, li or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transi Cause (Disease or i that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Pregnant at time of death Day Year ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? perform 1 🗌 Yes 2 🗆 No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify)#65 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred gevery, (Month, Day, Year) Natural 5 Pending injury work?
1 Yes 24 hours after death. Funeral Director: A 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORGAN CRNP 7300 Dularen Valla Monium 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #125Per of Mary and 124 englished. J. Health and Mental Hydiene

			1 - State Registrar		artment of H tificate of D		,		, ,	0000
			Decedent's Name (First, Middle, Last)		modito of D	- Catif	2. Date of Dea	Reg. No.	<del>]    </del>	4 3 2 0 8
	Physicia		GARY, MULLEN				Month	Day	Year	3. Time of Death
	Medio Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	09	26 201		14:35 M
	LAGITIII		GOOD SAHARITAN HOSPITE	0.1			МŊ	4c. County o	i Death	
Angel Co	Funeral			yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9 Rirth	place (State or Foreign
	Director		215-42-6848 1 XM 2 🗆 F 70		Months Days	Hours Min.	(Month, Day		Cour	
	}		Usual Residence of Decedent	115.			9-5-19	42	MARY	<b>LAND</b>
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	Mary 28a-i ptifie	irec	MD. N/A	BALTI	MORE				ĺ	Yes 2 No
	a or	O IE	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	nat Coul	ntry?
	s 23	Funeral Director	1340 GITTINGS AVENUE		212	239		USA		
	death item	Fur	11. Marital Status 12. Was Decedent Ever Armed Forces?		Vas Decedent of His Yes, specify Cuban	spanic Origin? (Spe	ecify Yes or No-	14. Race	Americ	an Indian,
36	after ", or amii	by	1 Never Married 2 X Married 1 X Yes 2 No	1980	☐ Yes 2 X No		nican, etc.)		White,	etc. IITE
8	ours attura	tec	Year or Dates 196	1-1967				Specify:		1111
5	72 h n "na fedio	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa and of work done du		ing	16b. Kind of Bus	iness/In	dustry
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an	e fi	မ	JAMES F. MULLEN				E M. ER	-		
춫	nould nd M in ar		19a. Informant's Name/Relationship (Type, Print)	10b Mailin	a Address (Street a				. 7:	
ž	I2sh Ilthau 27is rtrau				g Address (Street ar					·
ē,	f Hearlifem		MARY MULLEN SPOUSE 20a. Method of Disposition	20b. Place of Dispos	GITTINGS sition (Name of		BALT IM	ORE MD 20c. Location - C		
٦	age ento nt: If y or		1 17 Burial 2 Cremation 3 Removal from State	ST. JOSEP	atory or other place	) :	2-2012	FULLERT	•	·
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should se filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		Name and Address			FUNERAL		
Ã	permir Depar Impor any ir once.	3 10	1 Ben alle		705 BELAI	-		HAM, MD.		-
			23a. Part 1. Enter the disease, or complications that caused the							Approximate
-	Windston?		snock, or neart failure. List only one cause on each line.  Immediate Cause (Final							Interval Between Onset and Death
- !	Medical		disease or condition	ENSATE	D HYPER	CAPNO:	IC RESP.	ERATORY	4	Onset and Death
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88	certi	<b>≨</b>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of p	regnancy				23d. Date	of delive	en/
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<u>.</u>	that ned b	<u>ا</u> ۾	Part II. Other significant conditions contributing to death but n	ot resulting in the un	nderlying cause give	n in Part I.	23e. Did tol	oacco use contribi	ute to th	e cause of death?
Ġ,	luires an sig	ᄝ	ESRD, CHF				1 🗆 Y	es 2 No 3	☐ Prot	pably 4 🗆 Unknown
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5	<b>g Ph</b> erthi	<u>.</u>	27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury a	at :		w injury occurred	Specify	
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<u>s</u>	er de ecto by th	፱	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury -	At home, farm, stree	et, factory, office			reet and Number o	r Rural	Route Number,
Division of Vital Records,	talor rs aft al Dir		building, etc. (S)	peciny)		- 1	City or Town	, State)		13
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director, After this certificate completely filled in by the funeral director, pag	Medical	29a. Certifier  (Check 2 Medical Examiner: On the basis of exami	knowledge, death or	curred at the time,	date and place, ar	nd due to the cau	use(s) and manner	as state	d.
	the H hin 24 the Fi	Š	(Check 2 Medical Examiner: On the basis of examinonly one) 3 Certifying Nurse Practitioner: To the best	nation and/or investig st of my knowledge, o	gation, in my opinion death occurred at the	, death occurred at e time, date and pla	the time, date an ice, and due to the	d place, and due to e cause(s) and man	the cau	se(s) and manner stated. tated.
	No set to the set of t		29b. Signature and title of certifier		29c. License r	number		9d. Date signed (/		
			V. Hanasa HD.		RES	5000		09/21	6/1	2
	104		30. Name and address of person who completed cause of death		int)			-	•	
- 1	V		MANASA VULCHI MD	; BALTI	MORE	MD				
	State		31. Date filed (Month, Day, Year) 32 (tegistrar's S	Signature 2	Kal					
	Registra	r	OCT 0 5 2012   Stewa	B. Man						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 3, 2012 8:30A IVAN H. MARTIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOYOUS LIVING WHITE MARSH BALTO. If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Director 245-03-2636 1 ☐ M 2 🛣 F 92 NORTH CAROLINA OCTOBER 6,1919 Usual Residence of Deceden or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTO. MIDDLE RIVER 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6819 UNIVERSITY DRIVE 21220 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. δ Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Completed 3 ▼ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH BILLING GAS & ELECTRIC e 1 and 2 should be filed wir of Health and Mental Hygle If item 27 is marked other or other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN W. HENSLEY DOCHIA TIPTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN MURRAY DTR. 6819 UNIVERSITY DRIVE MIDDLE RIVER, MD. 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If if any injury or o 1 St Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) EBENEZER U.M. C. MIDDLE RIVER, MD. 10-6-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. all 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Vemenha disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the a d be detached f Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Grenia within 24 hours after death.

To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Astama 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify) 1 ☐ Yes 2 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Hospital Medical 29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination almost investigation, in my opinion, detailed and place, and due to the cause(s) and manner as stated | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number D31295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 701 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3209 State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Anna Mae Moore 01:39 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPITAL BALTIMORE AGNES If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Maryland Days Min. 212-28-9785 1 □ M 2 屎 F Hours (80)<sup>th</sup> P1<sup>y</sup>9<sup>y</sup>32 80 Yrs. **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🎦 No MD Baltimore Arbutus 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 5413 Highridge St. 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Manager Imports/Exports Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Melvin Smith Helen Lubek injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 604 Chester River Beach Rd., Grasonville, MD 21638 Karen Armin / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/5/2012 | Brooklyn Park, MD 22. Name and Address of Facility Ambrose Funeral Home 21. Signature of Fundal Service Licensee 1328 Sulphur Spring, Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by hyperlipidemia 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ANNA 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA Certificate: To 1 Inpatient 2 Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred MODE 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident A within 24 hours after deat To the Funeral Director. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29c. License numbe 29b. Signature and title of certifier D2264F Luy (Oor m) and address of person who completed cause of death (Item 23a) (Type, Print) 900 South CATON AVENUE BALTIMORE MANYLAND 21229 SNYDER rome 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 32092 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joy Nickey 8:56 am Medical PTEMPER 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPI TAI BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Hours (Month, Day, Year, Director 216-72-4888 1 □ M 2 🛱 F 56 Yrs. Usual Residence of Decedent March 6,1956 Maryland show 10a. State 10b. County filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2908 Delaware Ave. 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. <u>م</u> 1 Never Married 2 X Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 2XX No 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Food/ Double T Diner 12th N/A Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 Is marked o Howard Owings Virginia Harden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2908 Delaware Ave.,Baltimore,Maryland 21227 Samue 1 .T. No. 20a. Method of Disposition Nickey, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial XXX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Atlantic Crematory Oct. 3,2012 Glen Burnie, Maryland Signature of Funeral Service Licenses 22. Name and Address of FacilitAMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician barachoio hemorrha disease or condition resulting in death) 5 hours Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death the ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? ě Be Completed 1 Yes 2 No 3 Probably 4. Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 No 24 hours after death.

• Funeral Director: After this certifics letely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No |요 Other: ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical within 24 hou

To the Funer

completely fil 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 25489 mi SEPTEMBER. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANA ASA SMALT MENUE 900 CATON BALT IMO RE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g932 10-5-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ of to be 2012 00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** County of Death 4b. City Town, or Location of Death Himore If Un 8. Date of Birth (Morld), Day **Funeral** Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign
 Acountry) 1 🗆 M 2 🐼 F Months Hours Min. 2 **Director** Yrs. Usual Residence of Decedent or 28a-f show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 🗌 No MAK 10e. Street and Numb 10f. Zip Code ms 23a or must be r 10a. Citizen of What Country? 2 0 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. other traumatic event, the Medical Examiner Black, White, etc. 2 No ò 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates ac 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Docial Elementary/Seconday (0-12) College, (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည terso 19a. Informant's Name/Relationship (Type, Print) 24 Aug h 21 19b. Mailing Address (Street and Number or R 1 Route Number, City or Town, State, Zip Code) 21207 ma 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other pl 4 ☐ Donation 5 ☐ Other (Specify) 101 10 Woodlawn 21. Signatur f Funeral Service Licensee uneral and ddress of Facilie 453 Home, Bouto, MD 21216 23a. Part 1/Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of): Examiner REAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence or, attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Month Year detached 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No **Director:** After this certificate in by the funeral director, pag 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XX Natural iniury 5 Pending work? Accident Μ Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated extrifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only on 29b. Signa 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of GOPA KAMANA JMC ROSSROHDS 31. Date filed (Month ) Yell 32 State Registrar

DHMH 17 Rev 7/2009

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MICHAEL PLOTKIN/FATHER  803 BRICKSTON ROAD, REISTERSTONN, MD 21136  20a. Method of Disposition  12b Burlia 2 Committed of Disposition (Name of Cemeleny).  21 Signature of Disposition (Name of Cemeleny).  22 Name and address of Facility Sort. LEVINSON & BROS., INC.  800 REISTERSTONN ROAD, PIKESVILLE, MD  21208  22 Name and address of Facility Sort. LEVINSON & BROS., INC.  800 REISTERSTONN ROAD, PIKESVILLE, MD  21208  22 Name and address of Facility Sort. LEVINSON & BROS., INC.  8000 REISTERSTONN ROAD, PIKESVILLE, MD  21208  22 Name and address of Facility Sort. LEVINSON & BROS., INC.  8000 REISTERSTONN ROAD, PIKESVILLE, MD  21208  22 Name and address of Facility Sort. LEVINSON & BROS., INC.  8000 REISTERSTONN ROAD, PIKESVILLE, MD  21208  22 Name and address of Facility Sort. LEVINSON & BROS., INC.  8000 REISTERSTONN ROAD, PIKESVILLE, MD  21208  23 Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, shock or heart leaves on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, shock or heart leaves on conditions.  ARTCOLLE Intoxication  Due to (or as a consequence of):	d be fi ental arked vent,							
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Was decedent pregnant in the past 12 months?    Was a decedent pregnant in the past 12 months?   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year	ted ansit	E	Overtis resulting in death) Last	equence of);				
Was decedent pregnant in the past 12 months?    Was a decedent pregnant in the past 12 months?   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year	execu an and al - tra	Sa		,27,28a-f,pe	r me,g932 10-11-	-12 sm		
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Mary G. Rippie MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223					O.C.M.E.	s	eptember 29, 20	)12
	OCME	1	11. 11			1	<del></del>	
State 31. Date filed (Monting Sey Year) 2012 37 Registrar's Signature				A A	W. Baltimore Street, Baltin	nore, MD 2122	3	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Previak John 10.48 A October 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Baltimore ta 0 otimore Date of Birth If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. (Month, Day, Year, 213-58-3783 **Director** 1 X M 2 □ F 77 June 8, 1935 Hungary Usual Residence of Deceden 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Maryland Examiner must be notified at Director 1 Yes 2X No MD Baltimore Owings Mills 9 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 23a by Funeral 145 Fennington Circle 21117 , or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Roofer Roofing 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Previak Julia Budi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Friend Vincent Merlo 502 Berrymans Lane, Reisterstown, MD 21136 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/4/12 Hampstead, MD Cremation 21. Signatur of Juneral Solvice License 22. Name and Address of Facility 11824 Reisterstown Road æ nen Reisterstown, MD 21136 Eline Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 19 Medical Examiner Cass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed certificate | 1 ☐ Yes 2 ☐ No Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at work? Certificate: Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, water and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1163

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year,

0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LEN 10:45 AM 04 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death REISTERSTOWN Baltimore CHERRYWOOD CENTER FUTURECARE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Jan. 12, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2XXF Hours Min 215-09-2661 100 Yrs Director 1912 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes XX No Carrol1 Finksburg 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2508 Arabian Ct. 21048 U.S.A. items ; 72 hours after death Was Deceded... Armed Forces? 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: If Yes, Give Year or Dates Widowed 4 □ Divorced Completed Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) 12th and Mental Hygie is marked other Homemaker Own Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ of Health and Ments William Behn traumatic Ella Landgraph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Lois E. Pulket (Daughter) 2508 Arabian Ct., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem'1 Pk | 10/8/2012 Elkridge, MD Signature of Fune (1) and 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, MD 21117 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death ALZHEIMER ີh sician/ disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death Month 1 ☐ Yes ∠ ₽ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 M Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After s after deau... al Director: After X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed car

EREC ANAPOLSKY

31. Date filed (Month, Day, Year)

OCT 0 5 2012

e of death (Item 23a) (Type, Print)

6095

CRNP

32. Registrar's Şignature

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2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#30perPHYS, G932, I0/5/2012, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $0^{\text{Month}}$ ďĝ Lillian Richardson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 4000 Greenspring Ave. Baltimore N/A 5. Social Security Number 213-32-4296 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours (Month, Day, Year) Director 1 M 2 X F 76 03/11/1936 Virginia Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4000 Greenspring Ave. 21209 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Specify: Specify. Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress London Fog Manu Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ þ James C. Gregory Hester Daniels should permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie Richardson(daughter 4000 Greenspring Ave., Baltimore, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 09/25/12 Garrison Forest Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2JUSEPHOR SOE OWN Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 2. 1. Enter of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Betweer Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MANS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a quence of): the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ate has been signed by the atter page 2 should be detached for in the past 12 months? Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 10 No this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify, Hospital: 2 1 No 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) nd title of certifier 29b. Senature Sean Holmes

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

**Division of Vital** 

32. Regist

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State	of Maryla				alth and M	ental Hy	giene	20	10	2.2	000	0
		T - State Registrar Certificate of Death Reg. No. 2 1  1. Decedent's Name (First, Middle, Last)  2. Date of Death										<u> </u>	1	. Time of De	U S (	7
	Physicia		Louis Rosenbloo	,						Month 10	Day 2	$20^{\mathrm{Yea}}$		3:00	М	l
	Medic Examin		1a. Facility Name (if not institution,	give street and nur.		4b. City, Town, or Location of Death				4c. County of Death					١	
لمر			Suburban Hospit	a1 6. Sex				nesda			Montgomery					-
	Funeral Director		5. Social Security Number 579-10-7135	s. last birthday)	If Under Months		Under 24 Hrs. ours Min.	8. Date of Bir (Month, Da					oreign			
		ı	Usual Residence of Decedent	132 93						4-7-19	19	Wa	shin	gton,	DC	
	land F shov	tor	10a. State 10b. County			City, Town or L								Inside City		١
	28a-	Director	MD Montgo	mery	1 (6	Kensin						7147		1 X Yes 2	□ No	1
	ith the	ral	10e. Street and Number  5347 Strathmore	Arramita			10f. Zip (	395			0	en of What				l
	ems arm	Funeral	11. Marital Status	12. Was Dece	edent Ever in	U.S. 13	Was Decede	nt of Hispar	nic Origin? (Spe	cify Yes or No-		4. Race - Ar	merican I			1
2	fter de , or it amine		1 Never Married 2 Marri	ed Armed For 1 XYes If Yes, Given	2 No	WII	If Yes, specif		lexican, Puerto F	Rican, etc.)		Black, Wi Specify:	hite, etc. <b>Whit</b>	P		l
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2	filed tal Hy doth event	To Be	17. Father's Name (First, Middle, La	*					. Mother's Name			urname)				
Z	marke marke	٦	Barnett Rosenb			1401 140	Car A alabasas	_	Bessie (		-	Town, State, Zip Code)				
<u> </u>	2 sho Ith an 27 is i	1	19a. Informant's Name/Relationsh Phyllis Ballare		nter				, German							Ì
, U	1 and of Hea item other	1	20a. Method of Disposition		201	o. Place of Disp	oosition (Name ematory or oti	e of		ate	20c. Loc	cation - City	or Town	State		1
	Page ment c ant: If ury or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	udean			s 10-9-	-2012	01ne	ey, Ma	ry1a	ınd		
Daltillio	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fiem 27 is marked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	Edwa	ard Sag		22. Name and 1091 R		Facility Ed 11e Pike	dward S e, Rock	agel ville	Funer e, Mar	al I ylar	irect id 208	ion 52	
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that	caused the de								Ap Int	proximate erval Betwe	en :	1
	hysician/		Immediate Cause (Final disease or condition	Myoc	cardial	Infar	ction						Or	nset and De	ath	Į
J	Medical Examiner		resulting in death)	Due to	(or as a cons	equence of):							11			ı
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Our to (or as a consequence of):									1			1	
	uted id ransit	ami	Cause Enter I Inderlying Cause (Disease or injury that initiated events c												4	
	ate be executed physician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence of):													ı
9	physic physic the b			d						·	_					1
00	certific nding use as	II/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou		gnancy Fetal death 3	□ Fatania n	roananav			2	3d. Date of	delivery			ļ
DOX	death ne atte ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time		Other (spe				Month Day `			y Yea	ar	
5	at the d by th detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions								se contribute	bute to the cause of death?			1	
, L	uires th signe ild be o	Completed by	Acute Renal Fai	lure						1 🗆	Yes 2	□ No 3 □	Probab	ly 4 🖔 Ur	nknown	
Vital Records,	w requ	plete								24a. Was				findings av		
L L	The la ate ha page	Som								perf	ormed? 2 <b>X</b> No	death		_		
Ø	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:	-			Othor	of Death (Check							-
<u> </u>	Physi r this c eral dir	٠. ت	1 ☐ Yes 2 🛛 No 27. Manner of Death	28a, Date	of injury	ER/Outpat 28b. Time		Bc. Injury at	4 🗌 Nursing Ho	me 5 Res 28d. Describe			oecify)			-
	nding ath. r: After re fune	icate	1 Natural 5 ☐ Pendin 2 ☐ Accident Investig	9 '	nth, Day, Year,	) injury	М	work?	2 □ No							
DIVISION OF	r Atte ter de irector	Certificate:	3 Suicide 6 Could 4 Homicide determ	28e. Plac	e of Injury - A	t home, farm, s	treet, factory,	office		28f. Location City or To	Street and wn, State)	Number or	Rural Ro	ute Numbe	r,	
5	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		29a. Certifier 1 X Certifying	Physician: To the	hest of my kn	owledge, deat	h occurred at	the time, da	ate and place, a	nd due to the	ause(s) an	id manner a	s stated.			4
	n 24 h	Medical	(Check 2 Medical F	xaminer: On the ba	asis of examina	ation and/or inv	estigation, in n	ny opinion, c	death occurred at	the time, date	and place,	and due to t	he cause	s) and manr ed.	ner stated.	
	<b>7</b> With <b>2</b> Co <b>2</b> E	T	29b. Signature and title of certifier				29c,	License nui	mber		29d. Date	e signed (Mo		Year)		
			30. Name and address of person		100 of el-sty (1	tom 22=) /Time		V UU 6	1700		((	17/00	12			_
	10V		30. Name and address of person was Atul Rohatgi,					Beth	esda, M	arylan	d 208	16				
	Sta		31. Date filed (Month, Day, Year)	2.	Registrar's Sig	gnature ,										
	Registra	112	1651 15 5 7	415 / Klaud	<b>P</b> (4) / 4	CIC. SCHILLE	-									

Rosenbloom, Louis expired 10/2/12 23:00 pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#10d, perFH, G932, 10/5/2012 ws#4aperPHYS State of Maryland / Department of Health and Mehtal Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Day Z Month Physician/ 03:00A M RABINOWITZ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROLLING MEADOWS ASSISTANT LIVING CATONSVILLE BALTIMORE . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Hours (Month, Day, Year) Country) Director 219-16-4121 1 □ M 2 🗓 F 87 02/12/1925 Usual Residence of Decedent MDir than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 K Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6503 PARK HEIGHTS AVENUE 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: WHITE 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be WILLIAM  ${\sf ENGEL}$ ANNA GOLDBERG . Page 1 and 2 should trient of Health and M tant: If item 27 is mai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WENDY HAGERTY/DAUGHTER 7228 SECOND TIME LANE, COLUMBIA, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If is any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MEN 09/30/2012 WOODLAWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) mohoma ソむひにら Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24 hours after death.

Puneral Director; After this certificate has been signed.

Funeral director, page 2 should t 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No ☐ Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence ျ 1 🗆 Yes 6 10 Other (Specify) ASSIST CO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defitying Prijorcus 1 to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Rosenhal Caly very D31025 September 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) surpal mo Ballmore MD 2/20 608 Edgevale Road 31. Date filed (Month, Day, Yea OCT 0 5 2012 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9 Month 111920 20/3 0736 10 Medical 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** 4b. City, Town 1-Schoolhouse DUY sa Thers SOMER Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Mir 092-44-3853 **Director** 1 **X** M 2 □ F 44 Feb. 18, 1968 New York Usual Residence of Decedent 28a-f shov with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 ☐ Yes 2 X No Maryland Potomac Montgomery 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be Funeral 20854 2277 Dunster Lane United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married þ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", White Specify 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than traumatic event, the Me life. DO NOT use retired) within 7 Elementary/Secondary (0-12) College (1-4 or 5+) Writer/Director Film Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arnold D. Roth Linda Lasky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Marianne Roth/Wife 2277 Dunster Lane, Potomac, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 ី Cremation 3 🗆 Removal from State cemetery, crematory or other place, Oct. 3, 2012 Bethesda, Maryland 4 Donation 5 Other (Specify) Montgomery Crematorium Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Avenue, Rockville, Maryla Signature of Funeral Service Licensee kville, Inc. Maryland 20850 Wilhan M01173 23a. Part 1. Enter the disease, or complications find caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Beath Immediate Cause (Final Physician/ 5h51 disease or condition Medical resulting in death) Due to (or 6 a) onsequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) executed the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Yes 2 No be detached 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed should Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? certificate 1 Yes Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Hospital 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 
Natural 5 Pending work? s after death. -inflicted R M 2 No She 2012 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and planner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ure and title of certifier 29d. Date signed (Month, Day, Year) D ワッチ28 OCI sec moome

DHMH 17 Rev 06-2011

State Registrar 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo ont

Br

Lpa

31. Date filed (Month, Day, Year)

Stephen	Ε	Ransdell	
	_		

2-07349 Stephen E Ransd	lell	Please Type or State of	Print in Bla						gible.	0.0	0 001
·		I- For State Registrar		Reg. No. 2012 321							
Physicia Medical Examin	n/	Decedent's Name (First, Middle,Last)	Stanhan E	E, Ransdell				2. Date of Dea Month Septembe		Year	3. Time of Death 1530 hrs
		4a. Facility Name (if not institution, give st	reet and number)	, Kansuch	1 '	, Town, or Location	on of Death			nty of Death	
		1010 St. Paul Street Apt. 7C		(In one least births		timore	nder 24Hrs.	le Data of Bi	4b (144 4/D D 00	oool a pid	hplace (State or
Funeral Director		5. Social Security Number 6. Sex 1 ✓ M		(In yrs, last birtho	Yrs. Mor		urs Min.	1	21/1942	Foreig	
any	ł	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or	Location						10d. Inside City Limits
	اۃ	MD				Bal	timore				1 Yes 2 No
e Maryland or 28a-f show	Director	10e. Street and Number			10f. 2	Zip Code		1	0g. Citizen of		
with the Maryland ms 23a or 28a-f sho be notified at once.		1010 St. Paul Street					1220			U.	
ath wi	Funeral	1 Nover Married 2 Married	2. Was Decedent I Armed Forces?			dent of Hispanic ( cify Cuban, Mexic				ace - Ameri hite, etc.	can Indian, Black,
fter de	킰	3 Widowed 4 Divorced If	Yes 2 [Yes, Give Year Dates:	my 69-73	1 Yes	2 No speci	ify:		Speci	fy:	White
nours a	g Pa	15. Decedent's Education (Specify only h	nighest grade com	pleted) 16a. De		al Occupation (Giv			16b. Kind of	Business/li	ndustry
36 in 72 h		Elementary/Secondary (0-12) 12	College (1-4 or 5 5+	+)		Attorne				L	aw
21215-0036  Uld be filed within 72 hours after death with the Maryland Mental Hygiene.  Marked other than "natural", or items 23a or 28a-f she cevent, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, Last)				18. <b>M</b> oth	ner's Name (	First, Middle,	<b>[</b> Maiden Surna	ime)	
be file be file arked o	8		erry Ransdel						dith And		
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	٩	19a. Informant's Name/Relationship (Type Brian Daniel Ransdell / S		19b.		ss (Street and N urano Way,			nber, City or T	Fown, State,	Zip Code)
and 2 lealth :	ŀ	20a. Method of Disposition			Disposition (N	ame of cemetery,	T	Date	20c. Location	on - City or	Town, State
Baltimore, permit. Pages I an Department of Hee Important: If the injury or other tr	- 1	1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from Sta		y or other plac apeake C		10/	4/2012		Beltsvi	lle, MD
altir mit. P partme porta ury or	ŀ	21. Signature of Funeral Service Licensee	~1	./ 11		nd Address of Fac	ility		1		
	1	Dorota Marshall 23a, Part I, Enter the disease, of complica	ehell.M	Plenbro							ore, MD 21203 Approximate Interval
Physician Medical	-	failure. List only one cause on each	ine.						est, shock, or	rieart	Between Onset and Death
Examiner	-		theroscle to (or as a conse		ardiova	ascutar 1	Jiseas	<u>e</u>			
	اي	Sequentially list conditions, b.	e to (or as a conse	quanao of):							
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ecuted and and transit	EX	events resulting in death) Last Due	to (or as a conse	quence of):							
ĕ	힐		MENDED 23a,	pt.II,27	,per 1	ne,g932 ]	0-19-	12 sm			
Box 68760, c death certificate be ex the attending physician d for use as the burial	ğ.	Ob Man described management in the	23c. If yes, outcom	e of pregnancy						of delivery	
Ox 68 ath certifi attending or use as 1	Sal	past 12 months?	1 Live birth  Pregnant at t	ime of death 5	Other (S)		pic pregnan	су	Month	n D	ay Year
BOy e death the att	Physician/Medica		9 Unknown					T			
P.O. B es that the d igned by the detached		Part II. Other significant conditions co			n the underlyi	ng cause given in	Part I.	1 Yes			he cause of death?
w requires to been signal should be	Completed by	CHIOHIC AICOHOITS	u, ratty	river				24a. Was			opsy findings available
e law re has b	힐							autop perfo 1 <b>✓</b> Yes	rmed?	death?	ompletion of cause of
tal Rec		25. Was case referred to medical				26.Place of Dea	ith (Check or		2 140	1 🗸 Ye	s 2 No
Vital hysician:	P Be	1 ✓ Yes 2 No	oital: 1 Inpatier		patient 3			Home 5			Scene
Division of Vital Records, rate death or Attending Physician: The law requirers after death at Director: After this certificate has been sided in by the funeral director, page 2 should be an or the funeral director, page 2 should be a		27, Manner of Death  1 K Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	y 28b. Tii ar)	ne of Injury	28c. Injury at We	_ 1	28d. Describe	how injury occ	curred	
Atten Atten or death rector: by the	賈	2 Accident Investigation	28e. Place of Inju	ury - At home, farr	n, street, facto			28f, Location (	Street and Nu	mber or Rur	al Route Number, City
Division of the hours after dumeral Directly filled in by	Certification:	3 Suicide 6 Could not be determined	(Specify)		,			or Town, S			
		29a. Certifier 1 Certifying Physician:	To the best of my	knowledge, death	occurred at I	he time, date and	place, and c	lue to the caus	se(s) and man	ner as state	d.
To the within To the comple	Medical	one) 2 Medical Examiner: Or an 29b. Signature and title of certifier	the basis of exam d manner stated.	ination and/or inv		my opinion, death		une time, date			th, Day, Year)
	4	Zab. Signature and title of certifier			1	O.C.M.E.	-01			per 29, 20	
	-	30. Name and address of person who com	pleted cause of de	eath (Item 23a)					· ·		

Ana Rubio M.D., Ph. D. State 31. Date filed (Month, Day, Year)
Registrar 0 CT 0 5 20

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

COME

Bryant Ried		State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No. 2012	321
Physiciar Medical Examin		Month Day Year	ne of Death 505 hrs
)		BRYANT RICHARD RIED October 2, 2012 05  4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 6 Queen Anne Road Glen Burnie 4c. County of Death Anne Arundel	
Funeral Director		5. Social Security Number 213 80 1807 1 M 2 F 38 Yrs.   6. Sex 7. Age (In yrs. last birthday) 38 Yrs.   7. Age (In yrs. last birthday) 49. Birthplace Months Days Hours Min. 08 20 1974 Foreign Country)	(State or
any	F	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d. I	nside City Limits
		MD Anne Arundel Glen Burnie	Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  6 Oueen Anne Rd 21060 U.S.A.	_
15-0036 filed within 72 hours after death with the Maryland I Hygiene. ed other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at one	- L		dian, Black,
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hours a	2 -	45 Paris 1, 15 1 1 10 17 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin	pajaidillo	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Carpenter Constructi	on
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medica			
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imore, MD 2 Pages I and 2 shou nent of Health and N ant: If item 27 is n or other traumatic		Mary Albright - Mother   6423 White House Rd Moneta, VA 241   20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, Date   20c. Location - City or Town, 1	
10re, ages 1 a nt of He t: If ite	1	1 Burial 2 Cremation 3 Removal from State crematory or other place)	
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signatur of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Hom	
M 電点具語 Physician	4	169 Riviera Drive Pasadena, MD	21122
/Medical Examiner	1		veen Onset and Death
Exammer	l	or condition resulting in death)  Due to (or as a consequence of):	
	5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ted Insit	-49	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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S, P.O.  irres that the signed by defeatch	2	1 Yes 2 No 3 Probably 4	Unknown
Records, The law requires freate has been sig	2	24a. Was an 24b. Were autopsy fin autopsy performed? death?	
Vital Rec ysician: The his certificate director, page		1 ✓ Yes 2 No 1 ✓ Yes  25. Was case referred to medical  26. Place of Death (Check only one)	2 No
Vital  hysician this certi	١L	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA  Other 1 Nursing Home 5 Residence 6 Other: Scene	
ion of ' tending Ph eath. ior: After t the funeral		27. Manner of Death  28a. Date of Injury (Month, Day, Year)  1 Natural  5 Pending  fd 10-2-12  fd 04:45 am  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 X No  unknown	
Division of Vital Records, P.O. Box 68760, within 24 bours after death certificate be executed within 24 bours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transi indical Certificate Commission by Divisional Expenditure of the control of		2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Rout or Town State) 6 Queen Annual	
Divisi  To the Hospital or Ati within 24 hours after de To the Funeral Direct completely filled in by		4 Homicide (Specify) Single Family Home (Glen Burnie, MD.	Xu.
To the He within 24 To the Fu completely		(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	(s)
F 2 F 3		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day  O.C.M.E.  October 2, 2012	; Year)
	3	30. Name and address of person who completed cause of death (Item 23a)	
Stat	2 3	Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registra			
DHMH 17 Rev 1/2001 OCME 2006	I	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:44 PM 201 Elizabeth A. Scholz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Levindale Nursing Home 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 4 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Country)
MD Director 217-40-2424 943 69 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10a. State 10b. County at Director 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified MD Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1900 Grove Manor Drive 21221 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Peter Opszentkowski Betty Haffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Sipes (Daughter) 600 Middlesex Rd Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State jo = 9 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dogration 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Bayview Crematory 10/6/12 Baltimore, MD 21. Sign nure ral Service Licensee 22. Name and Address of Facility 300 Mace Avenue 21221 tello Connelly Funeral Home of Essex . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Stage End Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dedetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown cate has been signated based by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 X No After this certificate has completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No Certificate: To 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation after death Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURALYA BEGUM, MD 2434 WIBELVEDERE AVENUE, BALTIMORE, MD. 32. Registry s Sign State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2733ER Physician/ 1432 Sterling Stantield 2312 Medical 4a. Facility Name (if not institution 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore medster Harbor Hospita N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 237-64-8996 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🏻 M 2 🗆 F **Director** 05/29/1943 69 Yrs Carolina 28a-f show 10a. State 10c. City, Town or Location 10d Inside City Limits must be notified at Director N/A Baltimore 1 X Yes 2 ☐ No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 21223 U.S.A 19 S. Arlington Ave items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No ō þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 Xo Specify: If Yes, Give Year or Dates. Specify: Black 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12)
11th Grade College (1-4 or 5+) Contractor/ Carpenter Self- Employed Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o ...ye 1 and 2 should be ...ye 1 and 2 should be ...yepartment of Health and Mental Important. If item 27 is markay injury or other \*\* ပ Hattie I. FUller Thomas R. Stanfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 S. Arlington Ave., BAltimore, MD 21223 Annie Stanfield (wife) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10/06/12 Baltimore , MD Arbutus Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2) bsedhor brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ -ung They War disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Smoking Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transit Due to (or as a consequence of) iding physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy hours after death. Ineral Director: After this certificate 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, To Be Other: 1 Yes ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 1. Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Accident Investigation filled in by the Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month. Dav. Year) State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifie

Tram

To the Hospital

S. Hanover St. Baltimore, MD Mai doment 3001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Detrifying National Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29 c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear 1035 AM **Physician** Jane Frances Stromberg ctober 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Agnes HOSPITAL Birthplace (State or Foreign Country) Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 26,1938 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 👿 F 74 213-36-1238 Maryland Director Usual Residence of Decedent Od. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Medical Experiment must be rightled at 1 □Yes 2⊠No Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, Item Madical Experiment must be may injury or other traumatic event, Item Madical Experiment must be many injury or other traumatic event, 5148 Bonnie Acres Drive 21043 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ∐Yes 2XX No Baltimore, Maryland 21215-0036 Specify: Specify: ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Austin Shea Margaret Shriner ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7936 Dorsey Run Road; Jessup, MD 20794 Karen Stromberg Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crest Lawm Mem.Garden 10/9/12 Marriottsville, 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Strvice Licensee Funeral Home of Catonsville, Inc. Wah MO1234 1630 Edmondson Avenue; Catonsville Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine P.O. Box 68760,24 The law requires that the death certificate be executed ending physician and use as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 9 Unknown ייים ניווס כפרנוזוכמte has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 □Yes 1 □Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No Μ within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier The defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one)

State Registrar

29b. Signature and title of ce

Day,

Year)

30. Name and address

31. Date filed (Month,

29c. License number

D1858

29d. Date signed (Month, Day, Year)

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ oct 3 Dennis Singleton 2012 2:00P Keith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours Country Director 363-70-6956 53 1 XM 2 F 3/5/1959 MI if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the <u>Medical Examiner must be notified at</u> 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? Funeral 21158 4904 Arters Mill Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc. ð 1 Never Married 2 X Married ☐ Yes 2 ☐No 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Brick Mason Masonry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Singleton Doris Landeau should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Rebecca Singleton-wife 4904 Arters Mill Rd., Westminster, MD 21158 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Sykesville, MD 4 Donation 5 Other (Specify) South Carroll Crem 10/4/12 21. Signatu/ Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral & Cremation Main St., Westminster, MD 21157 E 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final CANCER Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completio death? Yes 2 1 Yes 2 No 25. Was case referred to examiner? Division of Vital edical Be 26. Place of Death (Check only one) Other: 4 \( \text{\text{Nursing Home}} \) 5 \( \text{\text{Residence}} \) 6 \( \text{\text{Other}} \) Other (Specify) 2 **D**No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifie 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed d death (Item 23a) (Type, Print) Da., Westminska, MD

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ October 2, Margaret Ann Sturgeon 3:43 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 151 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. Josephen, 2, 12 577-36-8905 Director 1 □ M 2 🕅 F 82 Nov. 11, 1929 Washington, D.C. in than "naturel", or items 23e or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Montgomery Bethesda 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4608 Chase Avenue 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Black, White, etc. Completed by ☐ Yes 2 X No 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Margaret (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Supervisory Secretary U.S. Government is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Menta John Dickinson Sturgeon, Sr. Clara Agnes Roache 19a. Informant's Name/Relationship (Type, Print) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is eny injury or other treu John D. Sturgeon/Brother 6817 Delaware Street, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 8, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Silver Spring, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01173 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 40512 Medical resulting in death) Due to (or a a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been accorded. Cause (Disease or i that initiated events burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 KNo Hospital: <u>유</u> 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in the cause of examination and/or investigation. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurses Practitioner: To the just of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manuer as stated only one 29b. Signature and title of certifier 29c. License number D0062435 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD Saned Molecular Elsayyad Dr 10110 mo 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

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		l - For State Registrar		C	ertifica	ate of	Death			F	teg. No.	20	12 3210
Physicia	n/	<ol> <li>Decedent's Name (First, Midd</li> </ol>		1						ath Day	Year	3. Time of Death	
Medical Examin	edical Examiner Gerard Francis Sheeran September 26, 2012									1857 hrs			
		<ol> <li>Facility Name (if not instituti</li> <li>2501 Boston Street</li> </ol>	on, give street and num	iber)		48	Baltimore Ci		f Death		4c. C	ounty of Deat	n
	4	5. Social Security Number	6. Sex 7	Age (In ve	s last hirth	nday)	If Under 1 Year		r 24Hrs 8	B Date of B	rth (MM/DE	0//YYY 9. Bi	rtholace (State or
Funeral Director		5. Social Security Number 150-36-9486 1 Mm 2 F 6. Sex 17. Age (In yrs. last birthday) 150-36-9486 1 Mm 2 F 63 Yrs.  150-36-9486 1 Months Days Hours Min.  February 19, 194									,194 <sup>Forei</sup>	<sup>gn</sup> New <sup>Duntry)</sup> Jersey	
any		Usual Residence of Decedent  10a. State 10b. County		10c. C	itv. Town	or Locatio	n						10d. Inside City Limits
<b>*</b>		New	mouth		reeh								1 Yes 2 No
Maryland 28a-f show	홠	Jersey Moni			LCCII		10f. Zip Code	-			10g. Citizer	n of What Cou	intry?
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with ms 23	Funeral	11. Marital Status	12. Was Dece		U.S.		Decedent of Hisp s, specify Cuban,				0- 14	Race - Amei White, etc.	rican Indian, Black,
r death	5	1 Never Married 2 N	1 Yes	2 X No	,				1 45.15 1 11	Jan, 010.7		pecify: Wh	:+0
s after			vorced if Yes, Give Year or Dates:		160	]	Yes 2 No s Usual Occupati	specify:	and of worl	k dono		d of Business	
hour	뒽	15. Decedent's Education (Spe Elementary/Secondary (0-12)			100.1	during mos	st of working life.	DO NOT	use retired	)	TOD. KIII	d of Busiliess	madatry
136 hin 72 e. than	휡	Elemental yrosositadi y (5 12)	2	,	M	ainte	enance W	orkei	_		Mai	ntenan	ce
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Baltimore, MI permit. Pages 1 and 2 to Department of Health a Important: If item 27 injury or other traum	1	21. Signature of Funeral Service	e Licensee				me and Address Harfor					the second second	21214
	-	23a, Part I. Enter the disease, o	complications that cau	sed the dea	ath. Do no								Approximate Interval
Physician Medical		failure. List only one cause	e on each line.										Between Onset and Death
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8760, ificate be g physici		IF FEMALE: 23b. Was decedent pregnant in t	the 23c. If yes, ou		egnancy	Feta	ideath 3	Ectopic	pregnancy	,		Date of deliver onth	Day Year
Box 68 death certification at the attending ad for use as 1	흥	past 12 months?	4 Pregna	nt at time of	death 5		er (Specify)						
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the is after death.  In Director: After this certificate has been signed by the funeral director, page 2 should be detach.	2			death but no	ot resulting	j in the un	denying cause gi	ven in Fai	11.1.				bably 4 V Unknown
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Vital Rec ysician: The l his certificate b director, page	ă١	25. Was case referred to medic examiner?	Hospital:	patient 2	ER/O	utpatient			Check only		Residenc	e 6 🗸 Othe	r Scene
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risic r Atte ter des irecto n by ti	<u>[</u> 2	2 Accident Inve	280 Place				factory, office be	uilding, etc	28	f. Location	Street and	Number or R	ural Route Number, City
Division pital or Attent ours after death teral Director: filled in by the	Certification:		ermined (Specify)	Fd:	in	water	r		Во	or rown,	State) An	Baltin	e Marina 2501 nore,MD.
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To With	Ě	29b. Signature and title of certif	and manner sta ier	ileu.			29c. License	number			29d. Da	te signed (Mo	onth, Day, Year)
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8			Assistant Medical			W. Bal	timore Street	, Baltim	ore, MD	21223			
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DHMH 17 Rev 1/200			2012		00	IGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Oct. 2, Rov Smith Michael 20192 5:09 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Westminster The Dove House Hospice Carrol1 Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) 217-40-4120 Director 69 1 X M 2 | F Oct. 21, 1942 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 311 Wampler Court 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X 14 Yes 2 17 No If Yes, Give Vietnam Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) MD. State Highway Admin. Paving Management Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item Z7 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Lee Smith Margaret Marie Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jerry Lee Weishaar/wife 311 Wampler Court Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 10/5/2012 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 5305 Hartord 22. Name and Address of Facility Leonard J. Ruck, Inc. VALVE Baltimore MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 🖸 No 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) PAME မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#26,27 per PHYS, G932 10/5/2012 ws State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ Eleanor Gertrude Stephens 12:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3224 Sudath Lane Harford Jarrettsville Social Security Number Birthplace (State or Foreign Country)
 Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral Director 218-18-5494 1 □ M 2 🛛 F 88 Yrs. Aug. 24, 1924 Maryland permit. Page 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examination to other treumetic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 403 Aggies Cir 21014 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Douglas Graves Daisv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3224 Sudath Lane, Jarrettsville, Maryland 21084 Mr. Michael W. Stephens Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 01, Gardens of Fatih Cemetery Rosedale, Maryland 2012 21. Signature of Funeral Service Licensee Joffmy R. To-M01543) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Bel Air 3 Newport Drive, Forest Hill 23a. Part 1. Unfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TERLOSCI Sequentially list conditions, day, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68766 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 Yes 2 No ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physicien: The eral Director: After this certificate filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) son's Other: 4 🗆 Nursing Home 5 Sesidence 6 🛣 Other (Specify) House 1 🔲 Yes 2 **N**O မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of ?8c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28d. Describe how injury occurred 5 Dending **X** Natural death, 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after c
To the Funeral Direct completely filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2012 30. Name and address of person e of death (Item 23a) (Type, Print) FAUSTO Q. とことな 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25,2012 11:00 A M SEPT. SABASTRO Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner N/A BALTIMORE 4903 E. CHASE STREET If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 583-34-2446 1 🛛 M 2 🗆 F Director FEB. 15,1951 PUERTO RICO 61 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State ms 23a or 28a-f sho must be notified at Director 1X Yes 2 No N/A BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21205 U.S.A. 4903 E. CHASE STREET ral", or items 2 Examiner mus death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 within 72 hours after 1X Yes 2 No Specific PUERTO RICAN 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. "natural", 3 Widowed 4 Divorced WHITE Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ROOFER CONSTRUCTION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ JOSEFINA SANCHEZ SABASTRO **GERARDO** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4903 E. CHASE STREET, BALTIMORE, MD SARA RIVERA SABASTRO/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State OAK LAWN CEMETERY: 10/2/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Full Service Licenses LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY Ph\_sician/ ARTERY DISEASE / Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ igned by the atter in the past 12 months? Month Day 1 Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed Jas ours after death. eral Director: After this certificate h filled in by the funeral director, pagi Yes 2 No To the Hospital or Attending Physician: i within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify,} \) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Descripting in places. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

クシ

State Registrar amouthe

AMRUTHA BALAKRISHNAN 2323 ORLEANS STREET BALTIMORE MD 21224

31. Date filed (Month, Day, Year) - 32 postpar's Signature

OCT 0 5 2012

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

D0071971

09,26,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CECILIA, SELUZICKI Day 2012 09:37 PM Month Physician September 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth NOV • 9,1916 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 95 Yrs. MARYLAND 218-09-2302 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County or 28a-f show notified at 10a State 1 ☐ Yes 2 🙀 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code r than "natural", or items 23a or the Medical Examiner must be n 1505 BETHLEHEM AVENUE 21222 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Black White etc. 1 Yes 21 If Yes, Give Year or Dates: ould be filed within 72 hours after Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes X No Baltimore, Maryland 21215-0036 Specify: þ Specify: WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any linjury or other traumatic ew once. LANGER WILFER JOHN BARBARA ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA AUPPERLEY/DAUGHTER 6909 NORMAN AVENUE, BALTIMORE, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

Signature of Fund State HOLY ROSARY CEMETERY 10/1/12 BALTIMORE, MARYLAND 21. Signature of Fu LILLY STEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 3 days SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Years ementia The law requires that the death certificate be executed attending physician and I for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23h. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) completely filled in by the funeral director, Be examiner? Hospital: 1 X Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 🏖 No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 Tes 2 No after death. Director: Aft 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Hospital 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0073802 September, 26,2012 MD 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print)

State Registrar

ate 31. Date filed (Month, Day, Year) trar

Majd

AlGhatrit, MI

32 Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 32113 Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month 835 A M argaret 5mith 2012 Oct Medical 4a. Facility Name (if not institution, give street and number) **Examiner** County of Death Newsing actors VI imor 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 207-34-6685 Hours (Month, Day, Year 09-03-23 Country) PA **Director** 1 🗆 M 2 🗓 F 89 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director BALTIMORE 1 🔀 Yes 2 🗌 No MD Catonsville ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a USA 21228 701 Edmondson Avenue 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. African ō 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: American Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10th Grade Nurses Aid Health Care and Mental Hygie is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jeraldine Madison Chick Smith Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3208 Barclay Street Baltimore, Maryland 21218 Leroy W. Smith- Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State Metro Crematory or other place) 10-08-12 Catonsville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List Immediate Cause (Final EREBRO VA FRATIL Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available 24a, Was an page 2 autopsy prior to completion of cause of death? performed 1 Yes 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this

filled in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on and title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) 10 28575 WU! 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBOX 1525, DWINGS MILL MJ 21117 ASNEEM mi State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SEPTEMBER ABBY SUE SILVERSTEIN Medical 11:19 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL OF BALTIMORE BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Country) Director 218-34-1213 1 🗆 M 2 🗓 F 76 07/26/1936 MD iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD BALTIMORE 1 Yes 2 X No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3315 WOODVALLEY DRIVE 21208 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🕅 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: "natural", If Yes, Give 3 Widowed 4 Divorced Specify. WHITE Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be .. Page 1 end 2 should be filed tment of Health and Mental Hy tant: If Item 27 is marked otl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMILET. SOKOL GERTRUDE GOLDSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EMANUEL SILVERSTEIN/HUSBAND SLADE AVENUE, #905, PIKESVILLE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State ₹ 5 Department of Important: If any injury or 4 Donation 5 Other (Specify) BETH TFILOH CEMETERY 10/03/2012 BALTIMORE, MD . Signature of Funeral Service Ligensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only pre-cause on each line. Approximate Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) 4 Macranu tterrurna Medical Due to (or as a consequence of) Examiner 12hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical examiner?
1 Ves 2 No **Division of Vital** 8 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practitioner: To the best of my killowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a nt title of certifie 0 30. Name and address of person who completed cause of feath m 23a) (Type, Print) Nea er 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>6</u> Physician/ SEPT **JAMES** STEVENSON 2012 5:06 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours 2/9/1941 NORTH CAROLINA Director 237-62-9359 NDM2□F  $71_{\rm Yrs}$ should be filed within 72 hours after death with the Maryland I and Mental Hygiene. I see marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC WASHINGTON 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1213 F ST20002 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married 쥧 1 Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th DRIVER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ GRAHAM STEVENSON SALLIE EASON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 2 <u>NORMA</u> STEVENSON/WIFF F ST NE WASHINGTON DC 20002 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FT. 10/4/2012 BRENTWOOD, MD LINCOLN CEM: 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE NE WASH., DC 20002 23a. Fart 1. Enter the disease, or shock, or heart failure, List or complications that caused the death. Do not)enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death Year Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has I performed? 2 No Yes 2 No 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗐 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, 24P<sub>M</sub> Physician/ CNOW October 201 Medical Facility Name (if not institution, Examiner give street and number, 4c. County of Death OHNS Kins HOSPITA Ba HOO more N/A 5. Social Security Number 7. Age (In vrs If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Month, Day, Yea March 28, Year) 218-88-9601 50 Hours **Director** 1 🗆 M 2 🕱 F Maryland 1962 Usual Residence of Decedent 28a-f show 72 hours after death with the Maryland at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified MD Prince Georges College Park 1 Yes 2 X No 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral 9014 Rhode Island Ave. #713 20740 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than, alth and Mental Hygiene.

27 is marked other than
er traumatic event, the Mo filed within Elementary/Secondary (0-12) College (1-4 or 5+) Bar Tender Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 2 Page 1 and 2 should be ment of Health and Ments William James Mathers Dreama Elaine Nicely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dreama E. Nicely Tecumseh Pass, Millsboro, DE. 19966 (Mother) Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory @ Loudon Park 4 ☐ Donation 5 ☐ Other (Specify) 10/5/12 Baltimore, Maryland 21. Signature of Funeral Service Licenses Loudon Park Funeral Home 22. Name and Address of Facility 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) as a consequence of): Examiner 051 Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of if any, leading to immediate Cause (Disease or injury that initiated events the burial-tran attending physician and Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Year been signed by the a should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed: after death.

Director: After this certificate 2 🗌 No 1 Yes 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) E5-000 Octob 2012 se of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar ober

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Orleans St

1800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Thomps	Dn	State of Man	yland / Depar <i>Certi</i>	tment of <i>ificate of</i>		Mental Hy	_	eg. No. 20	112 321			
Physic Vledical Exam			ık Thomps	son			2. Date of Dea Month Septembe	th Day Year er 25, 2012	3. Time of Death 0745 hrs			
		4a. Facility Name (if not institution, give street and Bon Secours Hospital	number)	4	b. City, Town, or Lo Baltimore	ocation of Death	·	4c. County of D	eath			
Funeral Director		5. Social Security Number 6. Sex 2 1 4 - 8 2 - 7 1 6 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	7		Birthplace (State or preign Country) MD			
nd <b>show any</b>		Usual Residence of Decedent  10a. State 10b. County  MD N/A	10c. City, To	own or Location	Baltim	ore			10d. Inside City Limits 1 X Yes 2 No			
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 2519 W. Baltimore	St.		10f. Zip Code 2122	3	10	Og. Citizen of What (	•			
r death wi or items must he	Funeral			If Ye	Decedent of Hispa s, specify Cuban, M	inic Origin? ( Spe flexican, Puerto R		14. Race - Al White, et	merican Indian, Black,			
5-0036 led within 72 hours afte itygiene. other than "natural", the Medical Exeminer	Completed by	15. Decedent's Education (Specify only highest g		6a. Decedent during mo	s Usual Dccupatior st of working life. D	O NOT use retire	d)	Specify: I	ss/Industry			
	Be	17. Father's Name (First, Middle, Last) Robert Eugene Fran		on Jr	. 18.	Mother's Name (	First, Middle, M	L Maiden Surname) n Martir	1			
imore, MD 2121 Pages 1 and 2 should be fi ment of Heath and Mental tant: If iten 27 is marked or other traumatic event,	To	19a. Informant's Name/Relationship (Type, Print) Linda Griffin (sis 20a. Method of Disposition	ter)	2519		timore		ber, City or Town, S Baltimor  20c. Location - City	e, MD 2122			
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and IA Important: If item 27 is in injury or other traumatic.		1	I from State crei	matory or other	• Park	10/0	3/12	Baltimo	ore, MD			
Physician		23a. Part I. Enter the disease, or complications tha	t caused the death. Dr	O   21	40 N. Fi	ılton A	ve.,		Approximate Interval			
/Medical Examiner			tensive Cars a consequence of):	rdiova	scular Di	sease			Between Onset and Death			
	aminer	Sequentially list conditions, if any, leading to immediate couse. Et al Undarphing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
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Box 6876( death certificate he attending physical for use as the b	Physician/Me	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnan birth gnant at time of death	2 Feta	I death 3	Ectopic pregnanc	у	23d. Date of deliving Month	very Day Year			
i, P.O. B ires that the d signed by the	þ	Part II. Other significant conditions contributing morbid obesity status	to death but not resul				_		to the cause of death?			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed	OS Was are affected to residue.					24a. Was an autops perform 1 Yes 2	y prior t ned? death				
Of Vitaling Physician After this cert uneral directo	: To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death 28a. Da		VOutpatient	3 DDA Oth	Death (Check onliner4 Nursing I	Home 5 R	Residence 6 Ot	her:			
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Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the it	cal Certific	4 Homicide determined (Specification Control of the determined of	est of my knowledge,					(s) and manner as s				
To th withii To th comp	Medi	one) 2 Medical Examiner: On the basi and manner  29b. Signature and title of certifier	stated.	or investigation	29c. License nu	umber		29d. Date signed (#	Month, Day, Year)			
X		30. Name and address of person who completed ca Russell Alexander MD. Assistant	use of death (Item 23a Medical Examine		/. Baltimore Str		e. MD 212	September 25,	<b>2</b> 012			
St Regist			R gistrar's Signature	be								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Year <u>Barbara Ann Voorhees</u> 6:55 a M October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glen Meadows Glen Arm Baltimore Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours <sup>Year</sup> 1922 Feb. 12, Massachusetts Director Yrs. 058-38-6749 90 Usual Residence of Decedent show 10a. State 10b. County notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 Tes 2 No Maryland Baltimore Glen Arm 9 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 10g. Citizen of What Country? Funeral 11630 Glen Arm Rd. Suite 2 21057 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Nidowed 4 □ Divorced Specify: Completed White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the 4 Homemaker <u>Own Home</u> Be event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev ဂ Herman Skerry Hall Margaret Robertson Husband 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Kirchner / Daughter 2411 Munford Drive, Fallston, MD 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State 10-9-12 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Elmira, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Ho 1317 Cokesbury Rd. Home, Abingdon. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Mheroscleratic Candiavascular Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Pregnant at time of death Month Year Day ed by the 9 Unknown g Unknown Division of Vital Records, P.O. signed t Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dresso Vascular 1 ☐ Yes 2 🖢 No 3 ☐ Probably 4 ☐ Unknown plnous Brillation Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? Yes 2 No Manuar death? 25. Wa case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man or of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 🗌 Yes 124 hours after death.
Funeral Director: Aftered filled in by the fur М 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) W)

DHMH 17 Rev 7/2009

State Registrar N Charles

30. Name and address of person who completed cause of death (Item 38a) (Type, Print)

MO

31. Date filed (Month, Day, Year)

) MERRY

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_		For State	State of Maryl		tificate of D	oath		-			
			Registrar  1. Decedent's Name (First, Middle, I	Last)	- 06/	uncate of D	Jairi	2. Date of Dea	Reg. No. 2	0 + 2	3. Time of De	ath
	Physicia Medi		Clementina	Ann	Vespig	gnani	2	Octobe	r <sup>Day</sup> , 2	0 <sup>Year</sup> 2	16:13	M
	Examir		4a. Facility Name (if not institution, g	ive street and number)		4b. City, Town, or L			4c. County	of Death	1	
البريد. ال	Funeral		Dove House  5. Social Security Number 6	5. Sex 7. Age (In y	vrs. last birthday)	If Under 1 Year	minster  If Under 24 Hrs.	8. Date of Birt	h	9. Birthpl	ace (State or Fo	oreign
	Director		146-16-4271	1 □ M 2 🖾 F 88	Yrs.	Months Days	Hours Min.	(Month, Day Sept 2	y, Year) 1924	Count	w Jerse	У
	nd thow at	٦	Usual Residence of Decedent  10a. State  10b. County	10c	. City, Town or Loc	cation				10	d. Inside City L	imits
	Maryla 18a-f s	rect	MD Bal	timore							1  Yes 2	<b>⊠</b> No
	th the	Funeral Director	10e. Street and Number	Design		10f. Zip Code	.209		10g. Citizen of		ry?	
	ath wil	uner	7011 Toby	y Drive	n U.S. 13. V	Was Decedent of His		cify Yes or No-	U . S	e - America	n Indian.	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Marrie 3 Never Married 2 Divorced	Armed Forces?	lf If	f Yes, specify Cuban,	Mexican, Puerto F	Rican, etc.)	Blac	white, e	tc.	
2-0	2 hour	Completed	15. Decedent' (Specify only highest		(Give k	dent's Usual Occupat kind of work done du	ion ring most of workir	ng	16b. Kind of B	usiness/Ind	ustry	
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ng	filed v al Hyg d othe	Be C	17. Father's Name (First, Middle, Las	st)			18. Mother's Name			e)		
yla	uld be 1 Ment marke natic	70	Angelo	Iannac			Nanc		eluca		-	
Maryland	2 sho Ith and 27 is r r traur		19a. Informant's Name/Relationship Gina Vespignan	i Daughter		ng Address <i>(Street ar</i> Toby Drive		more, N			ode)	
re,	of Hea		20a. Method of Disposition	20	Ob. Place of Dispos			ate	20c. Location		vn, State	
Baltimore,	. Page ment tant: If		1 😿 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify) D1		ge Cemetei		12	Pikesvi	11e,	Marylar	ıd
Balt	permit Depart Import any inj		21. Signature of Euneral Service Lic	m. Jenk	/ "	Name and Address LINE FUNE	1		eisterst erstown,		toad 21136	
<i>)</i>	cate be executed  Medical  Medical  Examiner  the prival-transit  the prival-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a constitution of the constit	sequence of):	L Perit	ONCAL	CAUC	(1W1W)		Onset and Dea	
. הטא מפנימם	eath certificate   attending phys I for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pre 1  Live Birth 2  4	Fetal death 3	Ectopic pregnancy			23d. Da			
	re des rthe a	ysi	9 Unknown	9 Unknown	ordeam 5	Other (specify)			Mo	te of delive	ny Day Year	
, r.	uires that the dea n signed by the a uld be detached i		9 ☐ Unknown Part II. Other significant condition:	9 🗌 Unknown		Other (specify)	n in Part I.		obacco use cont	nth ribute to the	Day Year	h?
necolds, r.O	The law requires that the dearate has been signed by the apage 2 should be detached.			9 🗌 Unknown		Other (specify)	n in Part I.	1 🗆 24a. Was autop	obacco use cont Yes 2 No an 24b.	ribute to the	e cause of death  ably 4  unk  sy findings avai  appletion of caus	h? known
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Sivision of vital necolus, r.o.	ysician: The law requires that the discordificate has been signed by the director, page 2 should be detached	Certificate: To Be Completed by	Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death	9 Unknown s contributing to death but not Hospital: 1 Inpatient 2 28a. Date of injury (Month, Day, Year ttion t be	t resulting in the uncertainty in the uncertainty and the uncertainty are supported by the uncertainty and the uncertainty are uncertainty and the uncertainty are uncertainty and the uncertainty are uncertainty and uncertainty are uncertainty are uncertainty and uncertainty are uncerta	26. Place t 3 DOA Other work?  M 1 Y	pe of Death (Check  4  Nursing Horat  at 2  es 2  No	24a. Was autop perfor 1  Yes only one)  me 5 Resided. Describe h	obacco use cont Yes 2 No an 24b. ssy rmed? 2 No dence 6 Oth. ow injury occurr	inth  3 Prob Were autoprior to condeath? 1 Yes	Pay Year e cause of death ably 4 Unk sy findings available from the cause 2 No	h? known
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DIAMETER DECORAS, F.O.	v requires that the do been signed by the should be detached	Certificate: To Be Completed by	Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes 2 No  27 Manner of Death 1  Natural 5  Pending 2  Accident Investiga 3  Suicide 6  Could not determine  29a. Certifier 1  Certifying P (Check 2  Medical Examiner)	9 Unknown s contributing to death but not  Hospital:  1 Inpatient 2 28a. Date of injury (Month, Day, Year  28e. Place of Injury - A building, etc. (Spe	2 ER/Outpatien 2 Sb. Time of injury At home, farm, streecify) nowledge, death o nation and/or invest	26. Place to 3 DOA Other work?  M 1 Yeet, factory, office	the of Death (Check  4  Nursing Horat  at	24a. Was autor period of the p	obacco use cont Yes 2 No an 24b. Yes 2 No dence 6 Othors ow injury occurr Street and Numb in, State) use(s) and manind place, and du	ribute to the 3 Prob Were autopprior to condeath? In Prob Were (Specify) ar (Specify) ar or Rural in the cau nanner as state	Pay Year  e cause of death ably 4 Unk sy findings avai upletion of caus Unk Poute Number, d. se(s) and manne ated.	h? known liable se of
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	amend # )  - State Registrar	Reference of Maryland / I	ck Indelible Ink, Er 32 10/05/2012 J Department of Healt Certificate of Deatl		iene <sub>99. No.</sub> 2012 3212
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (if not institution, give stree		atty,Jr.  4b. City, Town, or Location	Sate of Death	3. Time of Death
	5. Social Security Number 6. Sex	7. Age (In yrs. last birt	Months Days Hour	der 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign Country) 30 MD
he Maryland or 28a-f show i notified at Director	10a. State 10b. County MD NA  10e. Street and Number	10c. City, Town	imore		10d. Inside City Limits 1 □XYes 2 □ No 0g. Citizen of What Country?
death with th	5203 Garmouth Rc	Was Decedent Ever in U.S. Armed Forces?	21229  13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes or No-	U • S • A •  14. Race - American Indian, Black, White, etc.
d 21215-0036 ed within 72 hours after of Hygiene. Other than "natural", or ent, the Medical Examir Be Completed by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educa (Specify only highest grade of		1 ☐ Yes 2 🔀 No Spec Decedent's Usual Occupation (Give kind of work done during m life, DO NOT use retired)	post of working	Specify: Black  16b. Kind of Business/Industry  Fells Point
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Elementary/Secondary (0-12)  8th grade  17. Father's Name (First, Middle, Last)  William Watty Sr	College (1-4 or 5+) na	Packager 18. Mo		Wholesale Meats
b, Maryli, and 2 should the feath and Me im 27 is mark her traumatic	19a. Informant's Name/Relationship (Type, Marchele Watty-I	Print) 19b Daughter 52	. Mailing Address (Street and Nur.	nber or Rural Route Number, Road, Balti	more, Md 21229
Baltimore permit. Page 1 a Department of F Important: If ite my injury or ot	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)  21. Significant of Funeral Service Licensee	noval from State cemeter On-	i Disposition (Name of y, crematory or other place)  Site  22. Name and Address of Fa	10/2/2012	Baltimore, Md
Phylician Medical	23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one complete disease or condition resulting in death)  a.	SUBDURAL	- HEMORPH	as cardiac or respiratory arres	More, Md 21215  Approximate Interval Between Onset and Death
executed an and rial-transit Examiner	Soque tally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):	A Control of the Cont	
ox 6 ath cer attendifor use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnancy  1  Live Birth 2  Fetal death  4  Pregnant at time of death  9  Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (spec(y))	ne the first the second	23d. Date of delivery  Month Day Year
ords, P.O v requires that the speen signed by should be deta	Part II. Other significant conditions contrib	uting to death but not resulting i	n the underlying caus giv > A	1 ☐ Ye	
ital Recician: The law	25. Was case referred to medical examiner?	vital:	Other:	autops: perform 1 \sum Yes 2 Death (Check only one)	led? death? No 1 ☐ Yes 2 ☐ No
Division of Vital Records, P.O. Bo To the Hospital or Attending Physician: The law requires that the des within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached Medical Certificate: To Be Completed by Physic	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	1 N Inpatient 2   ER/Ou 28a. Date of injury (Month, Day; Year)   28b. T   2   2   2   2   2   2   2   2   2   2	ime of njury  **MOWN** 1	28f. Location (Str	w injury occurred Leet and Number or Rural Route Number,
Divis To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by Medical Cer	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner:	n: To the best of my knowledge, on the basis of examination and/o	death occurred at the time, date a r investigation, in my opinion, death vledge, death occurred at the time,	n occurred at the time, date and	ARMOUTH RD BALTIME se(s) and manner as stated. I place, and due to the cause(s) and manner stated
	29b. Signature and title of certifier	ND	29c. License numbe	93	2d. Date signed (Month, Day, Year) 9 26 25 12
State	30. Name and address of person who comp DANIE HAA. 31. Date filed (Month, Day, Year) OCT 0 5 2012	leted cause of death (Item 23a) (  SC 27 S G  32. Registrar's Signature	Type, Print) PEENE ST	BALTIMOR	E, MD 21201
Registrar  DHMH 17 Rev 06-2011	001 0 5 2012		PIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0500 A M 2013 Medical 4c. County of Death Bathmore If Unde Examiner enter moi 8. Date of Birth
(Month, Day, Year)
03-20-1923 Birthplace (State or Foreign Country) If Under 24 Hrs **Funeral** 1 **X** M 2 □ F Months Hours Min. Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count filed within 72 hours after death with the Maryland Director Yes 2 ☐ No MD BALTIMORE 10e. Street and Number 10a. Citizen of What Country? Funeral USA 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Yes Give 3 ₩Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the CAP Telephone Co Page 1 and 2 should be filed with trment of Health and Mental Hygien rrant: If item 27 is marked other 1 njury or other traumatic event, th Be UNK 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) ပ္ ral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 310 JOSEPHINE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

PRUID KIDE CEMEKRY 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🗷 Burial 2 □ Crematiøn 3 □ Removal from State 10/11/12 BACTIMORE, MD 4 Donation 5 Other/(Specify) GREENE FUNERAL SUNS Signature of Ineral S rvice Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ End disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No 9 Unknown ò 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Funeral Director: After this certificate has been signed a completed filled in by the funeral director, page 2 should be det Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed Yes 2 certificate has 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28h. Time of 27 Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29d Date signed (Month, Day, Year) KIJUZS9 30. Name athor wurner nd address of parson who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) -

DHMH 17 Rev 7/2009

		_	State Registrar	Cer	tificate of Dea	ath	Reg. I		2 3212			
	Physicia		1. Decedent's Name (First, Middle, Last)  Chester Raymond Wil:	son			2. Date of Death Month 09 16	2012 5 2012	3. Time of peath			
	Medic Examir		4a. Facility Name (if not institution, give street and num.  Future Care		4b. City, Town, or Loc Baltimor	cation of Death		lc. County of Dea				
المعمودين المسا	Funeral Director		5. Social Security Number 221 – 28 – 1217 6. Sex	7. Age (In yrs. last birthday) 68 Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Year 03/11/19	9. Bir 044 De	rthplace (State or Foreign ountry) Laware			
puelve	a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  MD N/A	10c. City, Town or Loc	cation altimore				10d. Inside City Limits 1 ★ Yes 2 ☐ No			
M ett the	23a or 28	Funeral Dire	10e. Street and Number 4800 Seton Drive	1 10	10f. Zip Code 2121	5	_	Citizen of What C	ountry?			
036	permit. Fage 1 and 2 should be filed within 72 hours enter death with the Maryland Department of Health and Mental Hyglene. Inoportment of Health and Mental Hyglene. In increase the manual state of their than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be rutified at once.	<u>۾</u>	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decer	2 <del>-122 N</del> o e 1	Was Decedent of Hispa f Yes, specify Cuban, M 1 ☐ Yes 2 ☐ MNo S		fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify: B1	te, etc.			
Baltimore, Maryland 21215-0036	ene. r than "natu	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-12th Grade	4 or 5+) (Give i	dent's Usual Occupation kind of work done durin O NOT use retired)	n ng most of working		Kind of Business on toome ard	/Industry			
land z	fental Hygi rked other tic event, 1	To Be (	17. Father's Name (First, Middle, Last) Aubrey Wilson			. Mother's Name (	First, Middle, Maide	n Surname)				
, Mary	alth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Aubrey Wilson(son)	19b. Mailir 7315	ng Address (Street and Kathyda	Number or Rural l	Route Number, City Baltime	or Town, State, Zi Ore, MD	io Code) 21207			
imore	ment of He tant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place) Crematory		/2012	Location - City or Baltimo	ore, MD			
Dair	Departiment any inj		21. Signature of Funeral Service Licensee	Illiano 21	sephyA44resBy  40 N. Fu.	rewn Jr lton Av	. Funer	al Home timore,	PA MD 21217			
	iysician/ Medical xaminer	er	Sequentially list conditions, b.	or as a consequence of):	Deels	ne Acid			Approximate Interval Between Onset and Death			
760 icate be executed	physician and is the burial-transit											
SIGH OF VICE DECOIDS, F.O. BOX OF	within 24 hours efter death.  To the Funeral Director: After this certificate hes been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ا∑ا	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year			
US, T.C.	in signed by uld be deta	ed by Ph	Part II. Other significant conditions contributing to de	eath but not resulting in the u	underlying cause given i	in Part I.			o the cause of death? Probably 4 D Unknown			
DIVISION OF VICAL RECORDS, all or Attending Physician: The law requires	ate hes bee page 2 sho	Complet	Proeme				24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of			
VII Call	s certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	Inpatient 2  ER/Outpatier	Othor	of Death (Check	only one)	6 ☐ Other /Soe	cifu)			
OTI OTI	ath. r: After this ne funeral	Certificate: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28c. Injury at work?		3d. Describe how inj		City			
DIVISION ATTENDED	urs efter de rai Directo lled in by ti	al Certif		of Injury - At home, farm, str ng, etc. <i>(Specify)</i>	eet, factory, office	2	8f. Location (Street a City or Town, Sta		ural Route Number,			
the Hosp	ithin 24 house the Funer	Medical	29a. Certifier 1	is of examination and/or invest	tigation, in my opinion, d	leath occurred at t ime, date and plac	he time, date and pla e, and due to the cau	ce, and due to the	cause(s) and manner state as stated.			
٩	. ≱ <b>₽</b> 8		· Com	in )	0 03	1464	29d. t	9 20	1 2			
0	21/		30. Name and address of person who completed caus  SHOALIS A ITASITMI M  31. Date filed (Month, Day, Year)  32. B	14 2	EM TAW	3 72	inte 36	8 Balt	my My 2			
	Sta Registr		OCT 0 5 2012	A. A.	who							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Clarke October Harry Ways Jr. 9:06 AM **Medical** 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 215-20-7010 1 X M 2 D F 86 July 13,1926 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Tes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3122 Gracefield Rd. #T-20 20904 United States items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status er than "natural", or iter the Medical Examiner 14. Race - American Indian Black, White, etc. 1 Never Married 2X Married þ 1 Yes 2 No
If Nes, Give
Year or Dates. 1944–46 Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Engineer Public Water Supply other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Harry Clarke Sr. Ways Romana Meyers traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Harry C. Ways, Jr. / Self 3122 Gracefield Rd. T-20, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State Chesapeake Crematory 10/05/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Dicensee Rapp a Famera Tacand Cremation Services M00382 Style & Tollman 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Ph. sician/ Onset and Death MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of resulting in death) Last Due to (or as a consequence of) sician a burial-Physician/Medical phys: Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Po in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Year 1 Yes 2 9 Unknown by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ as been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate ha Hospital or Attending Physician: The performed' 1 ☐ Yes 2 🗶 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after deat Director; Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in ! 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) OCTOBER 2, 2012 D68681

State Registrar

CHARU MAHESHWARY M.D., 1500 FOREST GLEN RD., SILVER SPRING, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 02 2013 Paul C. Wieczynski 10:07 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore <u>Towson</u> Funeral 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Months Hours Min. Director 215-14-5900 1XXM 2 □ F 90 February 10,1922 Maryland Usual Residence of Decedent 10b. County filed within 72 hours after death with the Maryland ir than "netural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Maryland Nottingham 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 Beagle Run 21236 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Area Manager Baltimore News permit. Page 1 end 2 should be filed w Department of Health and Mental Hygi Important: If item 27 Is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Felix Wieczynski Molly Cieslak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Wieczynski (Spouse) 21 Beagle Run Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October 04, Evans Funeral Chapel-Bel 2012 Forest Hill, Maryland 22. Name and Address of Facility Signature of Fuheral Service Licensee Evans Funeral 8800 Harford Chapel & Cremation Services
Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury After this certificate has been signed by the attending physician end funeral director, page 2 should be detached for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown 5 Other (specify) 1 Yes 2 9 Unknown Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA I Director: After this ed in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) n 24 hours af e **Funerel D**i eletely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated e and title 29b. Signatu 29d. Date signed (Month. Day, Year) D007178 10-3-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shaheen, 67 OIN. Charles 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 100 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Center Baltimore n/a 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Days Min. 220-14-2064 Hours sept. 20, 1919 Country) Director 93 MD Usual Residence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD n/a Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1819 Lydonlea Way 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black "natural" 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other tran "ns any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th <u> CareGiver</u> Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Barrett Ida Bond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allsberry/granddaughter 6220 Brook Ave. Apt 1 Balto.MD21206 Lawanda R. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Balto.NationalCemetery Oct .0,2012 Balto.Md Name and Addre CALVIN 1412 E ss of Facility
B. SCRUGGS FUNERAL HOME
PRESTON ST. BALTO. MD 21. Signature of Funeral Service er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Fnysician/ Medical resulting in death) Due to o as a consequence of) Hore Itran Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No Yes 1 Yes 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital 1 Yes 2 No 4 Nursing Home မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence ul Director: After this ed in by the funeral d After this 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Pate signed (Month, Pay, Year)

Ulover 4 certifie 3066 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 5601 With Rabbur Blood Baltimode SIREKSH TRIPURANENI Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Todd Jay Whitford State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0655 hrs **Medical Examiner** September 25, 2012 Todd Jay Whitford c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Baltimore County** Owings Mills 18 Silentwood Court If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Country) NM Director 10/16/1967 490-84-6784 44 1 XM 2 F Yrs Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10h County Owings Mills MD Baltimore 1 Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Department of Health and Mental Hygione (mportant: Hitem 27 is marked other than "natural", or items 23a or 28a-f the injury or other traumatic event, the Medical Examiner must be notified at once higher or other traumatic event, the Medical Examiner must be notified at once 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 18 Silentwood Court 21117 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12, Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes 4 Divorced If Yes, Give Year 1 986-91 White 屲 1 Yes 2 No specify: Specify 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Lab Technician Baltimore, MD 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jan E. Whitford Barb Whitford 19a. Informant's Name/Relationship (Type, Print baughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexis D. Whitford 313 East River Bend Drive Eaton GA 31024 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crem 1 Burial 2 Cremation 3 Removal from State 10/01/12 Glen Burnie MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Head Injury associated with alcohol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and ician/Medical AMENDED 23a, 27, 28a-f, per me, g932 10-10-12 sm ttending physician a r use as the burial -X UNPENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of deliver 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Month Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed<sup>a</sup> death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 Yes 2 No 28a. Date of Injury (Month, Day, Yea 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural subject fell while intoxicated 1 Yes 2X No Pending Director: d in by the f fd 9-25-12 fd 6:45 am 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 18 Silentwood Ct.
Wings Mills, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide determined Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) Medi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. September 26, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D. 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

31. Date filed (Month, Day Year) 32. Registrar Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October Physician/ 1037am eborah AWN 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death andalls town North WEST Balt Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Min (Month, Day, Year) Director 1 DM 2 F 06 50 62 07 en "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits death with the Maryland Director Baltimore 1X Yes 2 No NA MD 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21215 U.S.A. 3107 Glen 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married A Married 1 Yes 2 No If Yes, Give X Year or Dates. ould be filed within 72 hours after and Mental Hygiene. marked other then "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12th grade 2vrs Security Officer Security Agency other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file hand Mental H Willie Douglas Melvin H. Cade Sr. permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mai any Injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 Glen Ave, Baltimore, Md 21215 Yawn-Husband Ralph E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/8/2012 Baltimore, Md ral Service Lio 21. Signature of Fun 22. Name and Address of Facility 21215 4300 Wabash Ave Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Examiner Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed should be d ھا 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes director, page 2: autopsy 2 2 1 Yes 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No ဂ္ဂ 1 Impatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural  $5 \square$  Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D65843 October, 2,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Abdallah Kaffou NI, 5401 Old Court Road, Randallstown, HD 21133 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

12-07268 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Wayne Young State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Medical Examiner September 26, 2012 WAYNE YOUNG 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Hospital Center Prince George's Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Director Months Hours Min. 5 7Yrs. Country) WASH., DIC 5/13/1955 577-74-3899 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 1 XXes 2 No 23a or 28a-f show notified at once. imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.

ant: If item 27 is marked other than "natural", or items 13a or 28s-f sho no other trannatic event, the Medical Examiner must be notified at once. WASHINGTON DC Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4004 BLAINE ST NE 20019 UNITED STATES Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc. 1 X Never Married 2 Married Yes Specify: BLACK 1 Yes 2 No specify: 3 Widowed 4 Divorced Give Year <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th LABORER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VERMELL SMALLWOOD Be HOWARD <u>A</u> YOUNG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ည 19a. Informant's Name/Relationship (Type, Print) WAYNE PALMER/SON SHIELD CT HPPER MARLRORO 7108 RLBORO MD 2 ( 20c, Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, permit. Pab.
Department of .
Tuportant: If iv crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: NCOLN MEM 22. Name and Address of Facility APTTOL MORTUARY 21. Signature of Funeral Service Licen; 1425 MARYLAND AVE NE WASH., DC 20002 Part I. Enter the disease, or complications that caused the not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one caylse on each line. Between Onset and /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day nast 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown should be detached Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by Š 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available certificate has b rector, page 2 sh autopsy prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other this 1 Yes 28a. Date of Injury FOUND: Pay, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Subject shot thin 24 hours after acau...

o the Funcral Director: A 1 FOUND: Natural 1 Yes 2 ✔ No Pending Sep 25, 2012 2324 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 5024 H Street S.E., Washington, DC determined (Specify) Local Street 4 V Homicide

DHMH 17 Rev 1/2001 **OCME 2006** 

completely

Medical

State Registrar

29b. Signature and title of certifier

Ana Rubio M.D., Ph. D.

31. Date filed (Month, Day, Year)

OCME

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedlcai Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) September 26, 2012

32129

0011 hrs

Death

Year

2 No

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lucy Starr Adams 104 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico Year If Under 24 Hrs. Days Hours Min. 6 Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 214-66-8443 1 M 2 X 5-24-1955 MD Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Evantion must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🖵 Yes 2 🗆 No MiD Worcester Berlin 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 10358 Carey Road 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Receiver Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Granville Adams Doris Taylor permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic any injury or other traumatic angles. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Silva Rd. Stockton, MD. 21864 Jana Krabill-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place)
First State Crem. 9-19-2012 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Millsboro, DE 21. Signature of Funeral 8 22. Name and Address of Facility Burbage Funeral Home William St Berlin MD. Port 1. Enter the diffease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ seas disease or condition Medical resulting in death) consequence of) Éxaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 A Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🛣 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🖪 Natural injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RA 10 6507 DAVID WALKER 31. Date filed (Month, Day, Year) SEP 2 0 32. Registrar's Signature State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jonathan Wayne Allgaier **1**8. September 2012 12:39 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9111 Charterhouse Road Frederick Frederick 1 Year | If Under 24 Hrs. Davs | Hours | Min. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Dav. Year) Director 214-96-6762 1 X M 2 🗆 F 42 Yrs October 24, 1969 Washington DC Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 1 Yes 2 TNo Maryland Frederick Frederick 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 9111 Charterhouse Road 21704 United States of America death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Structural Engineer & Architect Self Employeed 5+ other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be Wayne Allgaier Victoria Elizabeth Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Tina Marie Allgaier / Wife 9111 Charterhouse Road, Frederick, Maryland 21704 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of F Important: If ite any injury or oth 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State September 22. Brunswick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Park Heights Cemetery Signature of run rall ervi e Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ I or Attending Physician: The law requires that the death after death.

Director: After this certificate has been signed by the atter for in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page perform 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year, 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 안 30. Name and address of person who completed cause of death (Item 23a) (Type  $\supset /$ 

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death <sup>™</sup>Step 10,<sup>™</sup>2012 Physician/ 10:06AM<sub>M</sub> Allamong Randall Dale Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland 518 Ridgewood Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Country MD Apr 2 1937 219-74-5671 1 M 2 D F 75 Director 10d. Inside City Limits 28a-f shov 10b. Coun 10c. City, Town or Location Director Allegany Cumberland MD 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō pe Funeral 21502 USA 23a 518 Ridgewood Avenue items 2 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S 11. Marital Status Armed Forces

1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ 'natural", or 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 white Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) disabled Be 18. Mother's Name (First, Middle, Maiden Surname)
Nina Easter Starrett Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 2 Lewis Brent Allamong 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Sole) 18103 Informant's Name/Relationship (Type, Print)
Raymond Allamond brother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 9/11/2012 Scarpelli Funeral Home PA Cresaptown, MD 4 ☐ Donation 5 ☐ Other (Specify) ature o Funeral Service Licensee 22. Name a Scarnet of Ferrieral Home. PA 21. Sig/ 108 Virginia Avenue: Cumberland, MD 21502 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca se (Final Physician/ disease or c dition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter the cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred To the mospinal within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funer 1 Natural injury 5 Pending Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year, ٥ Do059987 death (Item 23a) (Type, Print) Drive Cumberland MD 92550 Registrar

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			For	State of Ma	aryland				and M	lental Hy	/giene	Э	
			State Registrar		_	Cer	tificate of L	Death			Reg. No	<u>. 201</u>	2 32 33
	Physicia Medic		1. Decedent's Name (First, Middle, La Joseph Franci	,	III					2. Date of De Septe		± 17 2°6	3. Time of Death 2:55P <sub>M</sub>
-	Examin		4a. Facility Name (if not institution, give Frederick Memo		nita	1	4b. City, Town, o Freder		f Death			c. County of De	
	Funeral		5. Social Security Number 6. S			st birthday)	If Under 1 Year	If Under 2		8. Date of Bi	rth	9.	Birthplace (State or Foreign
	Director		578 – 62 – 7642 Usual Residence of Decedent	<b>∑</b> M 2 □ F	69	Yrs.	Months Days	Hours	Min.	(Month, D			shington, DC
	Iryland I-f sho ied at	Director	10a. State 10b. County  MD Freder	ick		, Town or Lo unswi							10d. Inside City Limits 12√2 Yes 2 □ No
	or 282	Dire	10e. Street and Number	ICK	DI	uliswi	10f. Zip Code				10a C	itizen of What	
15 10th Avenue 21716  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Company of the Avenue Status 14. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent of Hispanic Company of the Avenue Status 15. Was Decedent Status													USA
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5-	"nat "nat	be	15. Decedent's l (Specify only highest g		ŀ	(Give	dent's Usual Occup kind of work done	during most	of workir	ng	16b. I	Kind of Busine	ss/Industry
2121	within 7 giene. er than , the M		Elementary/Secondary (0-12)	College (1-4 or 5- 4	+)		ONOT use retired) litor				Pub	lic P	olicy
Baltimore, Maryland 21215-0036	ld be filed wit Mental Hygie larked other atic event, 拉	To Be	17. Father's Name (First, Middle, Last) Joseph Francis	Borda, S	Jr.					(First, Middle Jacks		Surname)	
, Mar	tnd 2 should lealth and Me im 27 is mar her traumati		19a. Informant's Name/Relationship ( Patti Snodgras		1	P.C	ng Address (Street ) BOX 4		Jeff	ersor	1, M	D 217	55
timore			20a. Method of Disposition 1 ☐ Burial 2 ဩ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		ce	tropo	osition (Name of matory or other place litan		9-20	) – 12	Al	exand	orTown, State ria, VA
Bal	permit. Page Department of Important: If any injury or once,		21. Signature of Euneral Service Licer	See			Name and Address 896,						
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line				^			rrest,		Approximate Interval Between *Quset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a			cular	HCC	106	nt			Days
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a									
	executed an and ırial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	CODSECU	ence off.							
	ate be exe ohysician the burial	ᡖ	resulting in death) East	d									
. Box 68760	Attending Physician: The law requires that the death certificate be executed at death.  **r death.**  **r death.*  **r death.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnand Other (specify)	су				23d. Date of Month	delivery Day Year
s, P.O.	ires that th signed by ld be deta	d by Pi	Part II. Other significant conditions	contributing to death bu	ut not resu	ulting in the L	underlying cause gi	ven in Part I	l.				to the cause of death?
Division of Vital Records,	The law requate has beer page 2 shou	Completed by								perl	opsy formed?	prior death	
<u>=</u>	sician: The certificate irector, pag		25. Was case referred to medical				26 P	lace of Deat	h (Check	1 L Yes	2 1	lo! 1 ⊔ `	Yes 2 □ No
Vita	/sicia s cert direct	To Be	examiner? 1 \( \) Yes 2 \( \) No	Hospital:	ent 2 🗆 I	FR/Outnatie	nt 3 DOA Oth	er _			idence	6 ☐ Other (Sp	acifu)
of	og Physicar this		27. Manner of Death	28a. Date of injur (Month, Day	y	28b. Time of injury		y at		28d. Describe			eury
o	ending leath.	fica	1 Natural 5 Pending 2 Accident Investigation	on	, , , , ,	,σ.,		Yes 2□	No				
Divisi	P affer affer a	Il Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		iry - At hor :. (Specify)	me, farm, str	eet, factory, office			28f. Location City or To			Rural Route Number,
	ne Hospital in 24 hours e Funeral pletely filled	Medical	(Check 2  Medical Exam	ysician: To the best of niner: On the basis of exrse Practitioner: To the	kamination	and/or inves	tigation, in my opini	on, death oc	curred at	the time, date	and plac	e, and due to the	e cause(s) and manner stated.
	To the I within 2 To the I comple		29b. Signature and title of certifier	sh mi			29c. Licens	e number			29d. Da	ate signed (Mo	nth, Day, Year)
	8		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, F	Print)	0-10-	5/	m	7.	700	
	Sta	te	31. Date filed (Month, Day, Year)	7/10 32. Registra	2 / Co ar's Signat	0 (( 17 V	7 1 (1	UP	ICK	11.11	<u> </u>	102	
	Registr	ar	2FF 8 0 3	1117		Di A							

DHMH 17 Rev 06-2011

12-06881 Jeffrey Evan Burton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar					Certifi	cate of	Deatl	h				Reg. N	lo.	0 :	
Physicia edical Examii	ın/	Decedent's Name (F     JEFFREY		,Last) VAN	BUR	RTON						. 2	Date of De Month Septemb	ath Dav	y Yea	r	3. Time of Death 0650 hrs
		4a. Facility Name (if no Southern Mary				umber)		4	b. City, T Clinto	own, or L	ocation of	f Death			4c. County of Prince G		
Funeral Director		5. Social Security Num 577-08-895		6. Sex	1 2 F	7. Age (	In yrs. last b	irthday) Yrs.	If Unde	r 1 Year S Days	If Under Hours	Min.				Foreig	thplace (State or in untry) DC
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location											09		10d. Inside City Limits			
ne Maryland or 28a-f show fled at once.	ctor	MD I		e Ge	eorges		Upper	Mar1	oro	Code				10a. C	itizen of Wh	at Cour	1 Yes 2 No
h the Ma 13a or 28	II Dire	4006 Fox	Gate							20772					USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status  1 Never Married		rried	12. Was De Armed F 1 Yes	orces?	ver in U.S.	If Ye	es, specify	y Cuban, I	Mexican,		cify Yes or N ican, etc.)	lo-	White	, etc.	can Indian, Black,
iours afte	2	3 Widowed  15. Decedent's Educa			Yes, Give Ye or Dates: highest gra		eted) 16a	. Decedent	's Usual (		n (Give k			16b	Specify: . Kind of Bus		Lack
036 ithin 72 h ne. r than "n	Completed	Elementary/Seconda	ary (0-12)		College (	1-4 or 5+)		ıdit 1		Ū			,		Privat	e	
215-0036 be filed within 7 ntal Hygiene. rked other than	Be Co	17. Father's Name (Firs											irst, Middle Swann	Maide	en Surname)		-
Men Men mar		19a. Informant's Name/	Relationsh	ip (Typ	e, Print )		1	9b. Mailing	Address					ımber.	City or Town	n. State.	Zip Code)
MD and 2 sho alth and as 7 is raumati		Michelle 20a. Method of Disposi		on -	- Wife	!		4006					pper l		lboro,		20772
Baltimore, bermit. Pages I an Department of Hea Important: If iter injury or other tr		1 X Burial 2 0	Cremation		Removal fi	rom State		atory or oth	er place)		.				Clinto		
Balti permit. Departm Importa		21. Signature of Funera			1 Jorg	11		22 N Ma	me and f	Address o	f Facility	Fune	ral H	ome	of Ma	ry1	and
Physician /Medical		23a. Part I. Enter the di failure. List only o	ne cause o	on each	line.												Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Fina or condition resulting in		Du	ardiac Ar	a consequ	ence of):	A au mm a	tria Laf	t Vantri	ioular U	h	, mb, r		<del></del>		3331
	iner	Sequentially list conditi if any, leading to immed cause. Enter Underlying	diate		e to (or as a		galy with a	Asymme	tric Lei	t ventri	iculai n	урепт	рпу				
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Box 68760, a death certificate be the attending physic deforuse as the burned for the burned for the burned deforuse as the burned deforuse deforu		IF FEMALE: 23b. Was decedent preg past 12 months?	gnant in the		1 Live b	oirth	of pregnancy ne of death	2 Feta	aldeath er (Speci		Ectopic p	pregnanc	у	2	3d. Date of o	•	ay <b>Yea</b> r
the death	Physicia	1 Yes 2 No 9			9 Unkn		ut not resulti				en in Part	11	23e Did	tobacc	o use contrib	eute to t	he cause of death?
s, P.O. uires that the n signed by ld be detach	百												1 Ye	es 2[	No 3	Proba	ably 4 🗹 Unknown
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed												1 🗸 Yes	psy ormed?	pr de		opsy findings available ompletion of cause of S
certi	a	25. Was case referred t examiner?	to medical	Hos	pital:					6.Place of				1		1	
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ion of ttending J leath. tor: Afte		27. Manner of Death  1  Natural  2  Accident	Pendir	ng igation	28a. Date (Month	of Injury , Day,Year)	286.	Time of In	· ]	8c. Injury	at Work?		3d. Describe	how ir	njury occurre	đ	
Divis	Certification	3 Suicide 6 4 Homicide	Could determ	not be nined	28e, Plac (Specify)	e of Injury	/ - At home,	farm, street	, factory,	office buil	lding, etc.	28	or Town,		and Number	or Run	al Route Number, City
o the Hos ithin 24 h o the Fun	Medical (			iner: 0		of examin									and manner a lace, and du		
	ž	29b. Signature and title	of certifier	N	all	) oct		-		License r					Date signed ptember		th, Day, Year) 012
105.11	t	30. Name and address Carol H. Allan,					h (Item 23a) miner 9	00 W. B	altimore	e Street	t, Baltin	nore, N	ID 21223				
Sta Regist	ate rar	31. Date filed (Month, D	A 201	2	32. Re	egistrar's	Signature	and									

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sep 26 2012 9:35 PM <sup>™</sup> Brake Helen Vera Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Devlin Manor Nursing Home Cumberland 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Jan 14, 1918 Director 214-07-0943 1 □ M 2 🗶 F 94 Usual Residence of Deceden 28a-f show 10a. State other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Cumberland Allegany 1X Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? by Funeral 10301 Christie Road 21502 USA or items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any hijury or other traumatic event, the Medical Examinance. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Allegany Co. School System teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Mattie Row G. William Corrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1111 South Geroge St. Ste. 11 Cumberland MD Guard.of Pers Rebecca Freeland Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Kremation 3 Removal from State cemetery, crematory or other placel Scarpelli Funeral Home, P.A. 9/28/2012 Donation 5 - Other (Specify) Cresaptown MD 22. Name and Address of Facility Scarpelli Funeral Home, PA Funeral Service L Ignature o 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused shock or heart failure. List only one cause on each line the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of): burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FFMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 Pes 2 No 23d. Date of delivery Ectopic pregnancy ō Other (specify) Month Day Year 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Hursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury - (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certifier 0 29d. Date signed (Month, Day, Year) t. 27, 2012 DO017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 70 NIT'L LaVale AJ135/lips Hing MD 21502 922 31. Date filed (Month, Day, Year) -State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryl State of Maryl Registrar		artment of H tificate of D			iene <sub>eg. No.</sub> 2 (	012	3213
Physician		1. Decedent's Name (First, Middle, Last)  Agnes  Marie	Comb	s		2. Date of Deat Month <b>Septemb</b>	n Day_	Year <b>2012</b>	3. Time of Death 8:20 P M
Medica Examine		4a. Facility Name (if not institution, give street and number)  St. Mary's Nursing Center			ocation of Death	Берестр	4c. County		
Funeral Director		220-26-4813 Usual Residence of Decedent 1 □ M 2 🕱 F 8	7rs. last birthday)  5 Yrs.  City, Town or Loc	If Under Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 07/10/1	ce (State or Foreign yland I. Inside City Limits		
h the Maryland a or 28a-f shu be notified at		Maryland St. Mary's  10e. Street and Number	Leonard	town 10f. Zip Code		1	0g. Citizen of V	What Country	1 Yes 2 X No
, or i	Completed by Funeral	20928 Camp Cosoma Road  11. Marital Status  1  Never Married 2  Married 3  Widowed 4  Divorced  15. Decedent's Education (Specify only highest grade completed)	16a. Deced	Vas Decedent of His Yes, specify Cuban  ☐ Yes 2 🗷 No  ☐ Yes 2 🗷 No	panic Origin? (Spe , Mexican, Puerto Specify:	Rican, etc.)	14. Race		nite
e filed within 7/2 ntal Hygiene. ed other than event, the Me	as l	Elementary/Secondary (0-12) College (1-4 or 5+)  11  17. Father's Name (First, Middle, Last) Charles Benjamin Morgan	Cai	O NOT use retired) E <b>eteria W</b> o	_		Publi laiden Surname Pills	)	ools
nd 2 should be filed lealth and Mental Hy m 27 is marked oth her traumatic event		19a. Informant's Name/Relationship (Type, Print)  Thomas N. Combs, Jr./Son	19b. Mailin	g Address (Street ar  Montgome	nd Number or Rura	Route Number,	City or Town, S	tate, Zip Coo <b>20620</b>	
permit. Page 1 and Department of Hea Important: If item any injury or other		1   Burial 2 ☐ Cremation 3 ☐ Removal from State	St. Fran	sition (Name of natory or other place cis Xavie Name and Address Mattingle 41590 Fen	r 09/2	5/2012		on, M	D
i. i. Medical Examiner the prial-transit	dical Examiner	resulting in death) Last Due to (or as a cons	sequence of): enh'a sequence of): mi`a	wh's					
death certificate attending ped for use as	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	egnancy Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delivery	ay Year
requires that to been signed by should be deta	ρ	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.				cause of death?
ian: The law re	Be Completed	25. Was case referred to medical examiner?		26. Pla	ce of Death (Chec	24a. Was ar autops perforr 1  Yes 2	y F	Vere autops prior to comp leath?	y findings available bletion of cause of
hysi his c	Certificate: To	1  Yes 2  No  Hospital: 1 Inpatient 2  27. Manner of Death 1 Natural 5 Pending (Month, Day, Yea) 20 Accident Investigation 3 Suicide 6 Could not be		of 28c. Injury at 28d. Describe			w injury occurre	ed	
Hospital or A 24 hours after Funeral Direc etely filled in by	Medical Cert	4 Homicide determined 286. Place of injury - Abuilding, etc. (Special Control of the Special Control of the Specia	ecify) nowledge, death on the control of the contro	occurred at the time,	n, death occurred a	t the time, date an	se(s) and mann	er as stated	e(s) and manner stat
To the within 2 To the I comple	M	only one) 3 Li Certifying Nurse Practitioner: To the best 29b. Signature and title of certifier  30. Name and address of person who confleted cause of death (	MD	29c. License			9d. Date signed		
PML State Registra			Three No	tch Rd.,	Но11уwоо	d, MD 20	0636		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Physician/ September 2012 11:49 Medical Joseph Herman Clarkson 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner St. Mary's Hospital Leonardtown Mary's 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** (Month, Day, Year) 07/05/1937 1 XM 2 □ F Months New York Yrs Director 577-50-1552 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland must be notified at Director 1 ☐ Yes 2 👿 No Maryland St. Mary's Valley Lee 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 19192 Nick Mattingly Lane items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 No 14. Race - American Indian Examiner Black, White, etc. 20 1 Never Married 2 X Married þ permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. "natural", Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Veterinary Technician Veterinary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Eleanor Rosemary Easton Clifford Anthony Clarkson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Nona L. Clarkson/Wife Box 212, Valley Lee, MD 20692 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ò Department o Important: If any injury or once. Memorial Cem 109/27/2012 | Leonardtown, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee FAMILIA DOUGH IV CLOCK Kathleen Santivasci M 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 22955 Hollywood Road, Leonardtown, MD M00872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Ph sician/ Ardine Min disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DOXIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-transit and resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death signed by the attendin 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎾 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 2 🗌 No 1 Ves 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: To the Hospital or Attending 5 Pending work s after death. M 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Jakkson.

State Registrar fleath (Item 23a) (Type, Print)

29b. Signature and title of/certifie

-25480 Pt Lookout Rd., Bldg 1, Leonardtown, MD 20650 31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year,

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 Medical 4a. Facility Name (if not institution, give street and number) Location of Death 4c. County of Death **Examiner** LaPlata Charles Civista Medical Center 1 Year If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months Days Hours Min. (Month, Day, Year, Director 220-42-2870 1 X M 2 🗆 F 65 04/30/1947 Prince Frederick. 28a-f show 10d. Inside City Limits 10a, State 10b. Count 10c, City, Town or Location Examiner must be notified at Director Brandywine Charles 1 Yes 2 X No Maryland 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5123 Peppermint Place 20613 USA items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. è 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No Specify Specify: White "natural", 3 Widowed 4 X Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Supervisor 11th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James F. Cooksey Elsie Mary Shlagel Cooksey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5123 Peppermint Place, Brandywine, MD Linda Parker / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/28/2012 Trinity Memorial Waldorf, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols Funeral Home M00817 30195 Three Notch Road, Charlotte Hall, MD 20622 23a. Part 1. Enter the clsease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying 7 ON the burial-transit Cause (Disease or injury that initiated events resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but if 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director; After this certificate has I 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Yes 2 No Hospital Other: ည 4 Nursing Home 5 Residence 6 Other (Specify ER/Outpatient 3 ПОА er of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. injury Natural 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, etermined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Che Certifying Nurse Practitioner: To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o 29d. Date signed (Month. Dav. 29b. Signatu 29c. License number nd address of person who completed cause of death (Item 23a) (Type, Print) end ON State Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Medical	(Check 2	Certifying  Medical E	kaminer	On the bas	sis of ex	amination	and/or invest	igation, in	my opinio	n, death oc	curred at	the time, date	and pla	ice, and du	ie to the	caus	e(s) and ma	ınner stated.
o the	Ž	only one) 29b. Signature and	Certifying	Nurse P	ractitione	r. To the	best of m	ny knowledge,		curred at the c. License		te and pla	ice, and due to		use(s) and Date signe				
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ sept. 2 Day 2012 2:03 AM Thomas Liam Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Ctr. Clinton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Days Hours Director 1 → M 2 □ F 09/21/2012 0 Maryland Usual Residence of Decedent if Health end Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 H No Belle Isle Orange FT. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States Funeral 32809 1612 Idaho Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Infant None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William David Chase Courtney Leigh Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Idaho Ave., Belle Isle, FL 32809 William D. Chase/Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 🗌 Burial 2 🛱 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) 09/29/12 Alexandria, VA Metro. Crematory 21. Sign time of Funeral Service icens 22. Name and Address of Facility Raymond Funeral Svc., M01517 MDLa Plata Washington Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 15 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the deeth certificate be executed Nat that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 4 🔲 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 □ No 1 X Yes 2 No To the Hospital or Attending Prystorian. within 24 hours efter death.

To the Funeral Director. After this certifice completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 0 4749 and address of person who completed cause of death (Item 23a) (Type, Print) 30 Name Day, Year) 31. Date filed (Mo State 2012 Registrar

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	Medic	al	Barry Edward Derr  4a. Facility Name (if not institution, give street and number)			l
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	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday	If Under 1 Year If Under 24 Hrs. 8. Date	e of Birth 9. Bi	thplace (State or Foreign
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than dical Examiner must be notified at	Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et	or No- 14. Race - Ame	
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Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once,				urbage Fune:	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve	occured at the time, date and place, and due to stigation, in my opinion, death occurred at the time.	the cause(s) and manner as sta	ated.
	the I	ĭ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	death occurred at the time, date and place, and du  29c. License number	e to the cause(s) and manner as	stated.
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			30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)	1/17/20	
1	3A10		30. Name and address of person who completed cause of death (Item 23a) (Type, Across and Across Acro	EASTERN SHORE DRIVE	VE STUBBURY	My 21804
	Stat	е	31. Date filed (Month, Day Year) 2012 32. Rigistrar's Signature	backer	-	
	Registra	ir	perior p. 1	P (4* 4* **		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ September 15 2012 Carla Ederine Dick 3:38 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 215-42-3434 69 Director 1 □ M 2 1 E Maryland May 11, 1943 Usual Residence of Decede "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector Maryland Frederick Thurmont 1 Yes 2XX No 盲 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13254 Catoctin Furnace Road 21788 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 0 Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical socce. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) aide Health Care dietary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Studebaker Pauline Remsburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21788 Gerald Powell - Friend 13254 Catoctin Furnace Road, Thurmont, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Blue Ridge Cemetery 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-22-2012 Thurmont, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home aray 1621 Opossuntown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RUPTURED THORACIC AORTIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician end impletely filled in by the funeral director, page 2 should be deteched for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No a ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 X Yes 2 □ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မှ 1 Na Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause within 24 hou

To the Fune

completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day Year) our 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701 400 W. 7th Street, Frederick, Maryland Rusu Florin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP Registrar

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			200	epartment of Health and I	Mental Hygie	ene	00110			
_			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2012 3214					
	Physicia		Paul W. Dorsey		2. Date of Death  Month	r 10, Year 2012	3. Time of Death			
	Medi Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
., j	1		5828 Drawbridge Court	Frederick		Frederick				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	ay) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth Cou	place (State or Foreign			
11.	Director		214-36-4160 Usual Residence of Decedent	Б.	01/17/19	01/17/1941 Marylan				
	fand f shov d at	ğ	10a. State 10b. County 10c. City, Town o				10d. Inside City Limits			
	Mary 28a-i	Director	MD Frederick Frede				1 🗶 Yes 2 □ No			
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		10e. Street and Number 5828 Drawbridge Ct.	10f. Zip Code 21703		10g. Citizen of What Country? United States				
	eath v tems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri				
36	after d ", or i	٥	1 ☐ Never Married 2 ☑ Married Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 XNo Specify:	Rican, etc.)	Black, White, Specify: Black				
00	atural cal Ex	Completed	3 🗆 Wildowed 4 🗀 Divorced Year or Dates.	ecedent's Usual Occupation	1.0					
21215-0036	in 72 h e. tan "n Medi	dmo	(Specify only highest grade completed) (G	ive kind of work done during most of work e. DO NOT use retired)	king	b. Kind of Business/Ir	ndustry			
7	ygiency ygiency her th	Be Co	9 Bus	Driver	T1	ransportat	ion			
Maryland	be filed intal Hy ked oth	10 B	17. Father's Name (First, Middle, Last) Paul Dorsey		ne (First, Middle, Maid	den Surname)				
ary E	should be file and Mental t is marked o raumatic eve			Alma Ho		ty or Town State 7in	Cadal			
	id 2 sh salth a n 27 is er trau		, , , , , , , , , , , , , , , , , , , ,	28 Drawbridge Ct.,						
ore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.			sposition (Name of crematory or other place)	Date 20	c. Location - City or T	own, State			
Baltimore,	it. Page rtment o rtant: If njury or		4 Donation 5 Other (Specify) Fairvi			rederick,				
Ba	permit. Departn Importa any inju	H	21. Signature of Funeral Service Licensee	22. Name and Address of Facility S 1621 Opossumtown P		uneral Hon				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not			erick, Har	Approximate			
	Ph_sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Postate C	ance		Interval Between Onset and Death			
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):	I TO SCILLE		· /	15 years			
	Examine	er	Sequentially list conditions, if any leading to immediate							
	ted           	Examiner	cause. Enter Underlying Cause (Disease or injury							
	executed an and rial-trans	EX	that initiated events resulting in death) Last C. Due to (or as a consequence of):							
09	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d							
/89	ertifica ding p se as t	l w	IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy							
ROX	death co	Physician/M	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year			
o C	the de	hysi	9 Unknown							
J.	s that gned I be dei	þ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		co use contribute to the	ne cause of death?			
rds	equire een si hould	eted			1 Tes	2 No 3 Pro	bably 4 🗆 Unknown			
Vital Records,	e law r has b ge 2 s	Completed			24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of			
<u> </u>	ificate	ė.	25. Was case referred to medical	26. Place of Death (Chec	1 🗆 Yes 2 🗓		2 🗆 No			
VII.	nysicia is cert direct	To B	examiner? 1  Yes 2 No  Hospital: 1  Inpatient 2 ER/Outpa	— Other:		e 6 Other (Specify	.)			
0	ing Pt		27. Mann of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time injury	e of 28c, Injury at	28d. Describe how in					
SIOL	ttend death stor: A / the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No						
DIVISION	al or A s after I Direct d in by		4 Homicide determined building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rurai tate)	Route Number,			
_	ospita Hours uneral	Medical	29a. Certifier  1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	nd due to the cause(	s) and manner as stat	ed.			
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  Of the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Me	(Check 2 Medical Examiner: On the basis of examination and/or into only one) 3 Certifying Nurse Practitioner: To the best of my knowled	age, death occurred at the time, date and pla	ace, and due to the ca	ause(s) and manner as	stated.			
	<b>₽</b> ≥ <b>₽</b> ⊗		29b. Signature and title of certifier	29c. License number		Date signed (Month, per				
			30. Name and address of person who completed cause of death (Item 23a) (Type	- 1		5	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	6		46 B Thomas Johnson Dr, S.	1-4/01/100	erick,	wo 21	702			
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	had I						
	negistra		OLT RULUIL MENSION C.	LO CRES						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 2012 13 11:15A M Sept. Medical Laura W. Davis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Capitol Heights Prince Georges 1532 Nova Avenue Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Min. Director 578-46-4355 1 M 2 XF April 28,1920 SC 92 Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at with the Maryland Director 1 X Yes 2 No PG Capitol Heights MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20743 United States 1532 Nova Avenue items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Was Deceus. Armed Forces? 14 Race - American Indian 11. Marital Status Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural" 3 X Widowed 4 Divorced Completed Black Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the care Provider Private Day 10 of Health and Mental Hygi item 27 is marked other other traumatic event, 1 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Unk. Vicie Faust 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1532 Nova Avenue Capitol Heights, Nancy Harris/Daughter MD. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of of 9/19712 cemetery, crematory or other place) Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem. Cemetery Suitland, MD 4 Donation 5 Other (Specify) Hodges & Edwards F.H. 22. Name and Address of Facility of Funeral Service Licenses Suitland, MD. 20746 3910 Silver Hill Rd., 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examil Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 use as IF FEMALE: attending 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ρď 5 Other (specify) Pregnant at time of death be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death?
1 Yes 2 No 2 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be Hospital: Other: 1 Yes 2 PNo 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred After 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, s after death. by filled in within 24 hours a

To the Funeral C

completely filled

> 45. State

Medical

29a. Certifier

only one)

Registrar

29b. Signature and title of certifie

Joiekine

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hou

263748

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Powder Mill Rd, Calverton, MD 20705

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 22, Physician/ 2012 Thomas Flanary 12:00 p.M. Kevin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Tall Timbers 44320 Tall Timbers Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 220-74-2196 1 X M 2 □ F Yrs. 03/22/1959 Maryland 53 should be filed within 72 hours efter death with the Maryland end Mental Hyglene.

Is merked other then "netural", or items 23a or 28a-f ehow reumetic event, the Medical Evaniner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Tall Timbers 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44320 Tall Timbers Road 20690 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 △ Yes 2 ☐ No 1 Never Married 2 Married Black, White, etc. Completed by Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes. Give 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Aircraft Mechanic Aircraft Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy Mae Carpenter James V. Flanary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 st Depertment of Heelth er Importent: If Item 27 is eny injury or other treu Tall Timbers, MD 20690 Box 52, Germaine B. Flanary/Wife P.O. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 09/24/2012 Charlotte Hall, MD 21. Signatura Ineral Service Scensee
Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 Jr. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, 1701 disease or condition resulting in death) Medical Due to (of as a consequence of): <sup>4</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) been signed by the ettending physiclen end should be detached for use es the buriel-transit thet the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant at time of death 9 Unknown Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospitel or Attending Physicien: The lew requires th within 24 hours efter death.

To the Funerei Director: After this certificate hes been signe completely filled in by the funeral director, page 2 should be or Attending Physicien: The lew requires t Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) Other: မြ 1 Yes 2 No 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? ☐ Accident 2 🗌 No Investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

10 Rml State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Jennifer Schmidt, D.O. 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #6 State of Maryland Department of Health and Mental Hygiene for State Registrar 32146 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 2012 5:45 P Kathleen Marie Fean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Lexington Park Chesapeake Shores Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 X M XX **Director** 051-16-1968 91 05/14/1921 Richmond Hills, Usual Residence of Deced 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes X No Charlotte Hall Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20622 USA 37740 Apache Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) Administrative Assistant Agriculture Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ Kathleen Sirlus Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 28669 Flora Corner Road, Mechanicsville, MD 20659 Dennis T. Fean / Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Maryland Veterans 10/02/2012 Cheltenham, Maryland Cemetery 22. Name and Address of Facility Brinsfield-Echols Funeral Home 21. Signature of Funeral Service Licensee M00817 30195 Three Notch Road Charlotte Hall, MD 20622 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line terval Betwee t and Death Immediate Cause (Final disease or condition Nemon Physician/ PIRATION Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 as the l attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Ď Dav ed by the a detached f 9 Unknown P.O. been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death? 1 Yes 2 No Yes 2 25. Was case referred to medical **Division of Vital** director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ည 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide the Hospital or Attending 5 Pending ours after death. eral Director: Aff filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the I 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 10) Rome egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ SEPTEMBER 27 2012 SALLY LOU FREDERICKS 09:54 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 8. Date of Birth (Month, Day, Year)
April 17, 1942 Connecticut If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** Days 212-46-1161 70 Director 1 □ M 24 F 28a-f show 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Moultail Examiner must be notified at 10d. Inside City Limits Director Maryland Frederick New Market 1 Yes 2 No 10f. Zip Code 21774 10e. Street and Number 10155 Vantage Point Court 10g. Citizen of What Country? U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 X Married ≥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Lewis F. Wheeler Aetna Earline Richardson 19a. Informant's Name/Relationship (Type, Print) Robert L. Fredericks, Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 10155 Vantage Point Court, New Market, MD 21774 Injury or other Hem 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1 a Department of H Important: If ite eny Injury or ot Smithsburg Crematory Sept. 30, 2012 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee <sup>22</sup> Nee Heydrand Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ared Medical resulting in death) Due to (or as a consequence of): Examiner ndios Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury yas a consequence of): ettending physicien and I for use es the buriel-transit that initiated events resulting in death) Last Due to (or as a conseque Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 pronths? Month signed by the e 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ۵ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital director, To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manper of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: Af
completely filled in by the fu Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nedical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Z Certifying Nurs Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a title of cer 29c. License number 3170L 30. Name and address of person ompleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Helen Charlene Graham rentemb Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death D **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Days Country **Director** 577-68-8829 1 M 2 X F 61 10/26/1950 Maryland and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show 10b. County Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? Funeral 36979 David Drive 20659 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dental Assistant Dentistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick H. Hoots Helen Yowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Donald M. Graham, Jr./husband 36979 David Drive, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. 09/26/2012 Cheltenham, MD 21. Signa vive of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. any in once. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00817 30195 three Notch Rd., Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death Physician/ tailune disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Dicela Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 F FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months tor; After this certificate has been signed by the atter the funeral director, page 2 should be detached for Month Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 ER/Outpatient 3 DOA Inpatient 27. Mann f Death Certificate: 28c. Injury at 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes Accident 2 🗌 No within 24 hours after death

To the Funeral Director; of completely filled in by the Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of centile 29c. License number 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 10) Rome

Registrar

DHMH 17 Rev 06-2011

		L	For	State of Man	yland / Depa	artment of H	leaith and	d Mental Hy	giene		
			State Registrar		Cer	tificate of E	Death		Reg. No.	0.12	32149
	Physicia	n/	Decedent's Name (First, Middle, Last)					Date of Dea     Month	ath Day	Year	3. Time of Death
	Medic		Deborah A. Grof					Sept.	<u> 16 2</u>	012	12:58p <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give str	reet and number)		4b. City, Town, or		ath	4c. County	·	
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	and shov	힏	10a. State 10b. County	10	Oc. City, Town or Lo	cation				100	I. Inside City Limits
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	the sec		10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	P
	is 23	Funeral	305 Beacon Poin	t Dr.		21903			USA		
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36	after i", or	ğ	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give		☐ Yes 2 No		, ,	Specify		
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<u>a</u>	d be f denta rked tic ev	요	Dr. C. Eugene	Miller			Mary	Bolger			
ary	and N and N is ma		19a. Informant's Name/Relationship (Type		19b. Mailir	g Address (Street a		Rural Route Number	r, City or Town, S	State, Zip Coo	de)
Σ	nd 2 saalth n 27 er tra		Glen Groff/ hus	band	305	Beacon	Point	Dr. Per	ryvill	e, MD	21903
ore	of Heroth		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Re		20b. Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Location	- City or Town	n, State
Ĕ	Pag ment tant: ury o		4 Donation 5 Other (Specify)		Lincoln	Cemeter	y 9/	21/12	Ephra		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "naturel", or items 23e or 28e-f show amy follury or other traumatic event, the Madical Examiner must be notified at once.		21. Signal uneral Service Licensee	117/	22	Name and Addres	s of Facility	neral Ho St. Risi	me, P.	Α.	
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	10		30. Name and address of person who con	npleted cause of death	(Item 23a) (Type, P	rint)	211)	00	Cae	, ) 1	175
	Stat	l	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	W 11	con	44	- 14 6	01	J.
	Registra		SEP 2 U	2012 \ Men	wa B.	Marke					

Contract of Death   Contract					Please	Type or ame	Print in nd #25	Black Ir	ndelible In	<b>k. Enşu</b> ı -20-12 Health ar	re All Copie	s Are	e Legible.			
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23. Part   Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Coronary Artery Disease  Due to (or as a consequence of):  Due to (or as a	altii	rmit. F partm porte y inju														
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Company   Comp	P.O.	that the		Part II. Other significant	conditions co	ntributing to de	ath but not res	sulting in the u	nderlying cause gi	iven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?		
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  1 Natural  28a. Date of injury  (Month, Day, Year)  28b. Time of injury  (Month, Day, Year)  28c. Injury at work?  1 Natural  28d. Describe how injury occurred  28d. Describe how injury occurred	Js,	uires 1 in sign uld be	ed b	Quadripleg:	<b>i</b> a						1 🗆	Yes 2				
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29a. Certifier (Check 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Marc R. Shepard, MD, 4700 Berwyn House RD., College Park, Maryland 20740	<u>~</u>	an: Th tificate tor, pa			medical				26. P	lace of Death		2XXN		2 🗆 No		
29a. Certifier (Check 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Marc R. Shepard, MD, 4700 Berwyn House RD., College Park, Maryland 20740	₹	nysicia lis cer I direc	P B		- "	lospital:	npatient 2 🔀	ER/Outpatier	Oth	or:		idence (	6 ☐ Other (Speci	ifv)		
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29a. Certifier (Check 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Marc R. Shepard, MD, 4700 Berwyn House RD., College Park, Maryland 20740	sior	ottend death ctor: / y the i	tific	2 ☐ Accident 3 ☐ Suicide 6 ☐	Investigation Could not be	28e Place	of Injury - At he	nme farm stre		Yes 2 □ No		/C++	d Alexander and December 1	10-11		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Marc R. Shepard, MD, 4700 Berwyn House RD., College Park, Maryland 20740	Divi	ital or A urs after ral Direc	al Cer			buildin	g, etc. (Specif)	)	(n) (1)		City or To	wn, State	e)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Marc R. Shepard, MD, 4700 Berwyn House RD., College Park, Maryland 20740		ie Hosp n 24 hou ie Fune bietely fi	Medic	(Check 2 ⊔ M	ledical Examir	<b>ier:</b> On the basi	s of examination	h and/or invest	igation. In my opini	on, death occu	rred at the time date	and place	e and due to the c	ause(s) and manner stated		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Marc R. Shepard, MD, 4700 Berwyn House RD., College Park, Maryland 20740		20 thi					///									
Marc R. Shepard, MD, 4700 Berwyn House RD., College Park, Maryland 20740		8.		1	19/10	ref	In	D0026382 9/					/18/2012			
		80														
State 31. Date filed (Month, Day, Year)  SEP 2 0 2012  32. Registrar's Signature			i.e			12 32. Re	gistrar's Signa	ture								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Maryland	-	tificate of E			Reg. No.	2012	32151
	Physicia	_	1. Decedent's Name (First, Middle, Last)		6	lenn		2. Date of Dea	ath Day	Year	3. Time of Death
1	Medic Examin		4a. Facility Name (if not institution, give si			4b. City, Town, or	Location of Dea		4c. Cour	nty of Death	
- stage	Euroval		The Johns Ho.  5. Social Security Number 6. Sex	PLINS HOSPIT		If Under 1 Year	If Under 24 Hr	s. 8. Date of Birt	N,	9. Birthp	lace (State or Foreign
	Funeral Director		219-26-3443		75 Yrs.	Months Days	Hours Mir	June 1	1 193	7 Mary	yland
	land show dat	tor	Usual Residence of Decedent  10a. State  10b. County		Town or Loc					11	Od. Inside City Limits
	ne Mary or 28a-f notifie	. <u>⊢</u> L	Maryland Anne Ar	undel Se	evern	a Park			10g. Citizen	of What Coun	1 ☐ Yes 2 No
	s 23a c nust be	Funeral	230 Ritchie Hwy			2114			US		
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۵	11. Marital Status  1 ☐ Never Married 2 <b>X</b> Married  3 ☐ Widowed 4 ☐ Divorced	<ul> <li>12. Was Decedent Ever in U.S. Armed Forces?</li> <li>1 ☐ Yes 2 X No If Yes, Give Year or Dates.</li> </ul>	- 1	Vas Decedent of Hi FYes, specify Cuba ☐ Yes 2X No		Specify Yes or No- erto Rican, etc.)	E	Race - Americ Black, White, e Cify: Blac	etc.
12-0	72 hours "natur edical	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give I	lent's Usual Occup kind of work done of O NOT use retired)	ation during most of w	rorking	16b. Kind o	f Business/Ind	dustry
212	within 7 giene. er than , the M		Elementary/Secondary (0-12) 12th	College (1-4 or 5+)		tenance	Super	visor_	State	e of 1	Maryland
and	be filed intal Hy ced oth	To Be	17. Father's Name (First, Middle, Last)  Johnson Glenn J	r				lame (First, Middle, E. Hal		ame)	
aryl	12 should be file lith and Mental I 27 is marked o r traumatic eve	Į.	19a. Informant's Name/Relationship (Typ	e, Print)	10			Rural Route Numbe			
e, Z	and 2 s Health tem 27		Althea Glenn(Wi			Ritchie		Severna	_,	, Md . on - City or To	
Baltimore, Maryland 21215-0036	Page 1 nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,	TT	.M. C	hurch	9-	28-12			ark, Md.
Balti	permit. Departr Imports any inji		21. Signature of Funeral Service License					ns Mort . Annap			21401
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only on	ications that caused the death							Approximate Interval Between
	Physician Medical			Onset and Death							
	Examiner	_	Sequentially list conditions	Due to (or as a conseque							
10	ted	Sequentially list conditions, fram, loading to him delations are used to be u									
	e execution and and unial-tra										
3760	ficate bu g physic as the b	-		d	-						
Box 68	requires that the death certifi been signed by the attending should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 L	Ectopic pregnand Other (specify)	су		23d.	Date of deliv Month	ery Day Year
Division of Vital Records, P.O. Box	quires that the signed by auld be detact	þ	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	underlying cause gi	iven in Part I.	- 1			ne cause of death?
Recor	: The law rec cate has been page 2 sho	Completed						1 🗆 Yes		4b. Were auto prior to co death? 1  Yes	psy findings available mpletion of cause of
Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner?1	lospital:	ER/Outpatie	Oth	lace of Death (Coner: 4  Nursin	check only one) g Home 5 ☐ Res	dence 6 🗆	Other (Specify	/)
υof	ling Ph J. Affer thi funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time o injury	wor		28d. Describe	how injury oc	curred	
ivision	l or Attend after death Director; /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)			1 (69 2 2 1 1 1 1 0		Street and Nu wn, State)	ımber or Rura	I Route Number,
29a. Certifier (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yes)									iuse(s) and manner stated.		
									Day, Year)		
			) Sons	g M.D.		D7	0622		Septe	ember	14,2012
,	5w		30. Name and address of person who c	ompleted cause of death (Item ANAKRY M	23a) (Type,	BOO Orlea	ins St	r. Baltin	voice, P	D 21	287
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JENNIFER ICANAKRY M.D., 1800 Orleans St. Baltimore, MD 21287  State Registrar  SEP 20 2012  September 14, 2012  September 14, 2012  JENNIFER ICANAKRY M.D., 1800 Orleans St. Baltimore, MD 21287  State Registrar  SEP 20 2012											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anthony Henriques State of Maryland / Department of Health and Mental Hygiene 2012 32152 1- For State Certificate of Death Registrar Rea. No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** Anthony Michael 1 Henriques 2325 hrs September 5, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Hospital Charles **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director 214-96-6987 Months Days Hours Min. 1 X M Country) New York 2 F 45 10/30/1966 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d Inside City Limits 28a-f show Maryland hours after death with the Maryland St. Mary's rector 1 Yes 2 X No Mechanics ville 10e. Street and Number 10g. Citizen of What Country 38998 Wanda Lane 20659 11. Marital Status 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. or items 14. Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces White, etc. 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify. White چ Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done pleted 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) item 27 is marked other than traumatic event, the Medical MD 21215-0036 12 Concrete Finisher Com Construction 17. Father's Name (First, Middle, Last) I and 2 should be filed Health and Mental Hyg 18.Mother's Name (First, Middle, Maiden Surname) Be Antonio Dasilva Henriques Maria Theresa Bayetis 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary T. Folden/Sister 38998 Wanda Ln., Mechanicsville, MD 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify! Queen of Peace 9/6/2012 Helen, Maryland 21. Signature of Fune of Service Lice 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 David A. Goff t I. Enter the di plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval ure. List only cause or /Medical Between Onset and a. Narcotic (Heroin) and Alcohol Intoxication Immediate Cause Fir al disease or condition resulting in death) ramine Death Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ned by the attending physician detached for use as the burial UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed icate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed certificate death? ✓ Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical Division of Vital Be 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA this Other Nursing Home 5 Residence 6 Other 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work' Certification: Sep 5, 2012 Natural Director: d in by the f 2300 hrs Unknown Pending hours after death 1 Yes 2 ✔ No 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2758 Hawthorne Road, La Plata, MD determined To the Funeral 4 (Specify) Single Family Home Homicide 29a. Certifier 241 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signativ e and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 6, 2012 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (MS) P State 324 Registrar's Signat

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 23, Year 2012 8:50 p.m<sup>™</sup> Francis Emmanue1 Hewitt Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital
Social Security Number 6. Sex St. Mary's Leonardtown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Months Hours 11/07/1928 Mary Land 214-28-4685 Yrs **Director** 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County items 23a or 28a-f shorer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Callaway 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21500 Point Lookout Road 20620 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner Lumber Supply Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eveni 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irving Graves Hewitt Edith Cecilia Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hewitt/Wife P.O. Box 318, Callaway, MD 20620 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Face Cemetery 09/27/2012 Great Mills, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOGACIOTAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** YEARL CORONSKI if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) YEMY CHEESTIVE burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IE EEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDCA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \sum Yes 2 \sum No 1 Natural injury 5 Pending Division 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) To the Hospital or within 24 hours aff To the Funeral Di Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 56e76 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARINING S. G'LL ST MARTS M

State Registrar 31. Date filed (Month, Day, Year,

SEP 27

. Registrar's Signature

OSPITAL

LEONDAN TOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:15AM Lowell K. Heinen 09/ Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veterans Home Mary's <u>Charlotte Hall</u> 8. Date of Birth (Month, Day, Year) 01/20/1938 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) **Funeral** Days 1 🛛 M 2 □ F Months Hours Min. **Director** 74 Maryland 217-34-8355 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other trans-10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No St. Mary's Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall Road 20622 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married ð 1 ☐ Yes 2 X No Specify: Specify: White If Yes Give 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sevurity Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margie Unknown Kenneth Heinen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29449 Tessa Washington/Case Worker Charlotte Hall Charlotte Hall, MD 20622 20c. Location - City or Town, State Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Brinsfield-Echols Crem 09/22/2012 Charlotte Hall, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 of Funeral Wice Licensee, 21. Signatur 44 MO0817 100 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADENOCARCINOMA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? ARTERIAL DISEASE PERIPHERAL 24a Was an r this certificate h performed Yes 2 🗹 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 19 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067788 MD 21,2012 Wille

State

Registrar

(1) Rme

KODALI - 14090 HGTrueman Road, Ste 2300, Solomons MD

20688

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EENA RAO

**SEP 27** 

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23.c.27, 28a-f., per me, g935 1-8-13 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 17, 2012 7:35 Physician/ Janet Lenore Heffner Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Takoma Park Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number (Month, Day, Year) **Funeral** Days Hours Maryland 1 M 2 X F 67 Dec. 23, 1944 Director 217-42-9858 Usual Residence of Decede 10d. Inside City Limits 10c. City, Town or Location 28a-f shov permit. Page 1 and 2 should be filad within 72 hours aftar daath with the Maryland Department of Health and Mantal Hygiana. important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machel Examiner must be notified at once. 10a. State 10b. County Director 1 Xx Yes 2 ☐ No Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21701 Funeral 406 East 9th Street 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Black White etc. Armed Force 1 Yes 2 1 No
If Yes, Give
Year or Dates. δ 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Anna M. Hawes James W. Heffner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5465 Hunting Horn Dr., Ellicott City, MD 21043 Keith Campbell / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 19, 20a. Method of Disposition Sept. 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Resthaven Crematory 2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. MD 21701 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or be at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Physician/ Due to (or as a consequence of): Medical Examiner Brain ANOXI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: Tha law raquires that the daath certificata be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Redords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d Date of delivery 23b. Was decedent pregnant Day in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 N 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Associated with surgery work? 1∐Yes 2.1&∑No 5 Pending 2 Accident -7-2012 unk Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State Washington Adventist Hospital Takoma Park, MD. 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined <u>Hospital</u> **Hospital** 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18, 2012 3796c mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 Carroll Ave. #350, Takoma Park, MD 20912 Sung Lee, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First\_Middle\_1 ast) 2. Date of Death Day 2012 Physician/ SEPT. 19 VERNA AVERILL HEWITT 7:34 PMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S GENERAL HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) **Funeral** Min. Days Hours **Director** 1 🗆 M 2 🗆 🗶 F 85 10-5-1926 BARBADOS Usual Residence of Deced iral", or items 23a or 28a-f show Examiner must be notified at 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ¥ Yes 2 ☐ No N CHRIST CHURCH, BARBADOS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 78 WARNERS PARK BARBADOS Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 XNo
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 han "natural", o 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Completed **BLACK** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 cf Health and Mental Hygiene. If item 27 is marked other than "rp or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) YEARS SCHOOL PRINCIPAL SCHOOL SYSTEM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CLAYTON ST. A. HEWITT ANNIE MAYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau ILENE L. HEWITT-SISTER-IN-LAW 1408 WHOOPING CT. UPPER MARLBORO, MD 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) DAVID'S CHURCH 9-28-2012 ST. DAVIDS, BARBADOS 21. Signature of Funeral Service Licensee C0203 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. - 8TH STREET, N. E. 524 WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No the Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 No 3 Probably 4 Unknown Completed 1 Yes Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 **X** No 1 Yes 욘 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: . After t 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.

I Director; Affid in by the fur Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the be st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 6JM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-201

State

32 Registrar's Signature

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 20<u>12</u> Physician/ Georgianna James Sept. 10, 5:59 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Hyattsville Saint Thomas More If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth Months Min (Month, Day, Year) Director 577-92-4770 1 □ M 2 🕱 F March 18, 1938 South Carolina 74 ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Hyattsville Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20782 United States 4922 LaSalle Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ō Black, White, etc. 1 X Never Married 2 Married þ 1 Yes If Yes, Give 2 XNo 72 hours after Maryland 21215-0036 Black 1 Yes 2 No Specify. Specify: "natural", 3 🗌 Widowed 4 🗆 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Compl (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7: h and Mental Hygiene. 7 is marked other than than Elementary/Secondary (0-12) College (1-4 or 5+) none n/a 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 unk. David James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 20006 Suite 300 Washington, DC 1629 K Street NW Cheryl A. Golloway/ Guardian Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Septate 21. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Clinton, Maryland Lee's Crematory Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sterry John 20019 Washington, DC M00560 4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph, sician/ Chronic Obstructive Plumonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal acc...
4 ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Year ed by the a 1 Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Rheumatoid Arthritis After this certificate has autopsy perform 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) September 18, 2012 D72168 35:M Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert McNeil, MD 4922 Lasalle Road Hyattsville, Maryland 20782 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 18 2012 Physician/ Keenan 12:45A M ptember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick Examiner 4c. County of Death Frederick Frederick Memorial Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month. Day, Year) Director 578-22-8910 1 🗆 M 2 🔯 F 97 Dec. 20, 1914 Massachusetts 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 2100 Whittier Drive 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 5 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: Specify:White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kastantas Munkavich Mary Mazeika 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Keenan / Daughter 24005 Whites Ferry Rd., Dickerson, MD 20842 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 e
Depertment of H
Important: If Ite
any Injury or ot Sept. Date 21, cemetery, crematory or other place 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Spēlcify) 2012 Frederick, Maryland 21. Signature of Funeral Service Licensi Restnaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Ogset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
24 hours after death.
5 Funeral Director: After this certificate has been signed by the attending physician end letely filled in by the funeral director, page 2 should be detached for use as the burial-trensit attending physician end I for use as the burlal-trensit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day Year g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} 2 🕅 No မ 1 Unpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier To the Hosp within 24 hou To the Funel completely fi 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year William E. Keck 09 2012 \_P <sup>M</sup> Medical 11:06 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 06/01/1931 Director 244-38-6218 1 □XM 2 □ F Yrs North Carolina Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified. MD Prince George's Suitland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4112 Offut Drive 20746 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No 5-1971

If Yes, Give 1965-1971 Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Airforce years Accountant Be Department of Health and Mental Hv. Important: If Item 27 is markany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Irvin Keck Fostena Everett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Flossie Keck/Wife 4112 Offut Drive Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial 09/21/2012 Suitland, MD f Funeral Service License . Signatule Marshall-March Funeral Home 22. Name and Address of Facility 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 X No Yes al or Attanding Physician: The safter death. I Director: After this certificat Division of Vital filled in by the funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined the Hospital o ithin 24 hours af the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check within 2 only one 29b. Signature and title of certifier 022 15500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SEPT Physician/ 2012 7:30 P M CAROLYN KING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) Director 1 □ M 2 🗓 F <u>577-70-6457</u> 1950 WASHINGTON, D.C DEC. 7, 61 or than "natural", or items 23a or 28a-f show the Me I cal Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Ty Yes 2 No PRINCE GEORGES LARGO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 9801 CEDAR HOLLOW LANE U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 🖾 No 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) O.P.M. GOV'T SECRETARY or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ GEORGIANNA CALVIN ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVE SHORT/FRIEND 9801 CEDAR HOLLOW LANE, LARGO, MD. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 9-19-2012 4 Donation 5 Other (Specify) CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, CLEVELAND AVE. RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death SEPTIC Immediate Cause (Final SHOCK Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any bedding to min dial cause. Enter Underlying Cause (Disease or injury that initiated events Examine ULLEST. the Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and linector, page 2 should be detached for use as the burlat-re-Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Day Month Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SCLENOSIS. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No ٥ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident (Month, Day, Year) To the rucepture after death, within 24 hours after death, To the Funeral Director: After the funeral will filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 2 9/14/2012

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUAWN SHAWM, WARKNIGTON ADVENTICT HOSD, TAKOMA PALK, HD-20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sept. 15, 2012 Physician/ 10:05 M Kim Medical Young 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forest Glen Nursing & Rehab Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours 8 M 9 1 5 7 1 9 3 2 Japan Japan 218-08-2655 80 Director 1 M 2X F Advanced that hygiene.
Independent of the state of the st 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or Items 23e or 28e-f sho Director 1 Yes 2 No Olney Montgomery MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral Korea 20832 18216 Allwood Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Asian 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tong Bun Kim Yong Ha Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 18216 Allwood Terrace Olney, Md 20832 Jin Ho Yu/ Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Removal from State Gate of Heaven Silver Spring, Md 9/19/2012 any injury o 4 Donation 5 Other (Specify) 21. Signature of 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the chease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Parkinson's Disease Medical Due to (or as a consequence of) <sup>/</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ending physicien and r use as the buriel-trensit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlel-<u>trensit</u> Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Day Month Year Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? 1 ☐ Yes 2 🙀 No Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sept.17,2012 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1355 Piccard Drive Rockville, Md G.Coleman 31. Date filed (Month, Day, Year) State Registrar

GEORGETTE KALACHIAN Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Certificate of Death  Reg. No. 2012 32											32161	
			Registrar		Cei	tificate of L	Death		ieg. No.			
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-	Medic Examin	al .	4a. Facility Name (if not institution, give s			4h City Town o	Location of Deatl		4c. County		0:13 A M	
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	nd now	_	Usual Residence of Decedent  10a, State  10b. County		10c. City, Town or Lo	cation		Jan. 1,	, 1931	Ť	. Inside City Limits	
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	or 28	흅	10e. Street and Number	icry	OTHEY	10f. Zip Code			10g. Citizen of N			
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9	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show the Marken Evaminer must be notified at.	۵	1 Never Married 2 Married	1 Yes 2 K	No	1 ☐ Yes 2x No		o nican, etc.)	200	ck, White, etc.		
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Maryland 21215-0036			19a. Informant's Name/Relationship (Typ			ng Address (Street				state, Zip Cod	e)	
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	Medical Examiner		resulting in death)	Due to (or as a	consequence of):	-	1000			13		
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Box 687	th cer ttendi	ian/	in the past 12 months?	3c. If yes, outcome of	2 ☐ Fetal death 3 ☐	Ectopic pregnanc	;y			ite of delivery onth Da	y Year	
œ.	requires that the death certific been signed by the attending should be detached for use as	Physician/M	1 🗌 Yes 2 📈 No 9 🔲 Unknown	4 ☐ Pregnant at g ☐ Unknown	time of death 5 L	Other (specify)			IVIC	Titil Da	y real	
P.0.	hat th ed by deta	by Pr	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	bacco use cont	ribute to the c	ause of death?	
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Ž	Physic this c	은	1 Li fes 2/3 No		nt 2 ER/Outpatie		4 LI Nursing F	lome 5 Reside	ence 6 🗌 Oth	er (Specify)		
27. Manner of Death  28a. Date of injury  (Month, Day, Year)  28b. Time of injury at work?  1												
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29b. Signature and title of certifier  29c. License number  29d. Date signed (Manth, Day, Year)								Year)				
	2		20. Name and address of names who are	mpleted source of di	oth (Itom 22a) /T	Print)	3		111	.120	10	
Amit Rajvanshi MD 121 Congressional Ln. Rockville, MD 20								D 20852				
29d. Date signed (Manth, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Amit Paj vanshi MD 121 Congressional Ln. Pochville, MD 201  State Registrar  31. Date filed (Month, Day, Year)  SEP 19 2012  32/Registrar's Signature												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 16, Day 2012 Year Richard Robert Langer 9:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 26070 Hills Dr. Mechanics ville St. Mary's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 187-22-4706 Director 1 XM 2 □ F 83 Feb. 21, 1929 PA Usual Residence of Decedent 28a-f shov at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director an "natural", or items 23a or 28a-f s Medical Examiner must be notified St. Mary's Mechanicsville 1 Yes 2xxNo 10e. Street and Number 10g. Citizen of What Country? Funeral 26070 Hills Dr. 20659 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3XXWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Master Sergeant U.S. Marine Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) and Mental Fisherships is marked o |George Langer Kathryn Langer Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a: If item 27 is Mary Rose Calvert/Daughter P.O. Box 2237 LaPlata, Md. 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If it any injury or o once. 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State Sacred Heart Church Cem. 9/22/20 2 LaPlata, Md. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Signatur 22. Name and Address of Facility Arehart-Echols Funeral Home, PA M00945 P.O. Box 567 LaPlata, Md. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph<sub>y</sub>sician/ THERO-SC HEART EROTIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dusito (or as a consequence of, that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown P.O. | þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed ! 23e. Did tobacco use contribute to the cause of death? þ ERTENSION Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown AORTIC ANEURYSM 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

VIDYASAGAK

Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANMANGANDLA

DHMH 17 Rev 06-2011

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0026064

29d. Date signed (Month. Day, Year)

10583-THEODORE GREEN BLVD WHITE PLAINS, MD - 20695

09-19-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ 09/16/20P2 Benedicto Seismundo Lagman 5:19 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5115 Vest Lane Waldorf Charles Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 578-76-9331 Hours Min (Month, Day, Year, Director 1 **X**] M 2  $\square$  F 78 05/10/1934 Philippines | show at 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Charles Waldorf Maryland 1 Yes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5115 Vest Lane 20601 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces' Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Black, White, etc. filed within 72 hours after ☐ Yes 2 No Maryland 21215-0036 1 Yes 2XXNo Specify. Specify: Filipino If Yes, Give Completed 3 Widowed 4 X Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Self - Employed Painter 17. Father's Name (First, Middle, Last) 2 should be file and Mental Haris marked of 18. Mother's Name (First, Middle, Maiden Surname) Federico Pangilinan Lagman Mercedes В. Seismundo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Lucrecia Lagman / Sister-in-law 5904 Blackhawk Drive Oxon Hill, Maryland 20745 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State 09/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. Clinton, Maryland Signature of Funeral Service Licer 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Schem disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam that the death certificate be executed and burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): Medical Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No g | Ilnknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law has autopsy performed certificate 1 Yes 2 No ☐ Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural iniury 5 Pending s after death. ☐ Accident ☐ Suicide Investigation n 24 hours after dez le Funeral Director pletely filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License numbe wina

Registrar

DHMH 17 Rev 06-2011

State

Yahia M. Tagouri MD

20650

leaneltour

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 2 0 2012

31. Date filed (Month, Day, Year)

Lookent

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2.5 Physician/ 2012 12:45a.Mn September Ann Cannon Marshall Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hollywood St. Mary's 24344 Mt. Pleasant Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign (Month, Day, Year, Director 223-22-5168 1 □ M 2X□ F Yrs. 88 19 81 1924 Virginia 10a. State 10b. County filed within 72 hours after death with the Maryland "naturel", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20636 24344 Mt. Pleasant Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3X Widowed 4 □ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4 or 5+) t. Page 1 end 2 should be filed with travent of Health and Mental Hygier trant: If item 27 is marked other t njury or other treumetic event, th Civil Service Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Colman Frank Leslie Cannon Rosaline 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara C. Anderson-Greenwell 24344 Mt. Pleasant Road, Hollywood, MD 20636 permit. Page 1 end 2 Department of Health Important: If item 2 eny Injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specity) 09/28/2012 Wakefield, VA Wakefield Cemetery 21. Si produce of oner life of the 22. Name and Address of Facility Brinsfield Funeral Home, Edward N. Brinsfield, 22955 Hollywood Road, Leonardtown, MD 20650 Jr.M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ AD disease or condition resulting in death) Medical Due to (or as a consequence of): <sup>'</sup>Examiner gels displaced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a confequence of The law requires that the death certificete be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an after death.

Director: After this certificate has I autopsy performed? 1 Yes 2 No Hospitel or Attending Physicien: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending iniury Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R06335 cusses 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3) Rme Dana Russell, N.P. 41680 Miss Bessie Drive, Leonardtown, MD 20650 31. Date filed (Month Day Year) SEP 28 Registrar's Signatur State Registrar

		State of Maryland / De	partment of Health and I	Mental Hyg	iene	0016					
	_		ertificate of Death	T	eg. No. 201	2 32 16 1					
Physicia		1. Decedent's Name (First, Middle, Last)  Marilyn Diane Monte		2. Date of Deat Month Sept.	h 19 2012	3. Time of Death 12:30 PM					
Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	-	4c. County of Deat						
بر 		2105 E. Old Philadelphia Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Elkton  If Under 1 Year   If Under 24 Hrs.	Table sales	Cecil						
Funeral Dírector		214-58-3376	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Con	hplace (State or Foreign untry)					
nd wor	_	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or		12-16-1	1946   Ohi	O 10d. Inside City Limits					
Aarylar 8a-f sk tified a	recto	Maryland Cecil Elktor				1 ☐ Yes 2 🔀 No					
IOFC, MICLYJETIC Z.1.21-0030  ge 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 2105 E. Old Philadelphia Road	10f. Zip Code 21921		0g. Citizen of What Co						
eath wi	nue	11. Marital Status 12. Was Decedent Ever in U.S. 1	Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	United Sta						
affer de	þ	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 🏋 No Specify:	Rićan, etc.)	Black, White Specify: Wh	e, etc.					
2-UU30 2 hours after "natural", o edical Exam	eted	3 Wildowed 4 Divorced Year or Dates.	cedent's Usual Occupation		16b. Kind of Business/						
Z I Z lin 72 t le. han "n e Medi	Completed	(Specify only highest grade completed) (G.	ve kind of work done during most of work DO NOT use retired)	king		il idusti y					
d with Hygien wither th	Be C	11 HC	memaker	ne (First, Middle, M	Own Home						
yiand Id be filed Mental Hy narked oth	인	Elmer Prather		ia Unknov	,						
Midry 2 should th and N 27 is ma trauma	-	1	ailing Address (Street and Number or Run	al Route Number,	City or Town, State, Zip	Code)					
and 2 Health tem 2)		20a. Method of Disposition 20b. Place of Di	haggy Oak Drive, E		aryland 219 20c. Location - City or						
Page 1 ment of ant: If it			ard Funeral Home,		Rising Sun,						
Dallimore, permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Funeral Service Licensee	22. Name and Address of Facility $R$	Γ. Foard	Funeral Ho	ome, P.A.					
	Н	23a. Part 1) Enter the disease or complications that caused the death. Do not	111 S. Queen St., I			Approximate					
- Ph. sician/		shock or heart failure. List only one cause on each line.	Restin Prelmone	is Dis	20.40	Interval Between Onset and Death					
Medical Examiner	resulting in death)  a. Due to (or as a consequence of):										
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uted Id ansit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):										
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ath certificate be executed attending physician and for use as the burial-transit	Physician/Medical	d									
h certificatending par use as	an/N	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 ☐ Live Birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of del						
e death of the atter	ysici	in the past 12 months?  1  Yes 2 No 4 Pegnant at time of death 9 Unknown	5 Other (specify)		Month	Day Year					
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duires een sig ould b		Diahetes Mellitus		1 🛂 Ye	es 2 No 3 Pr	obably 4 🗆 Unknown					
e law requires has been sig ge 2 should b	Completed	typertension Morbid Obesity		24a. Was an autops	y prior to d	opsy findings available completion of cause of					
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hysicish his cer	To Be	examiner? 1	Other:	,	nce 6 🗆 Other (Speci	fy)					
ding P h. After ti funera	27. Manner of Death  28. Date of injury  28b. Time of injury  28b. Time of injury  28c. Injury at work?  M 1 Yes 2 No  28c. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number)										
Attendir er death. ector: Af by the fu											
urs after or sitted in											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic	fedic	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To th withir To the	29b. Signature and title Certifier 29c. License number 29d. Date signed (Month, Day, Year)										
		Jachden 5 MD	00023322		9.21.	20/2					
3		30. Name and address of person who completed cause of death (Item 23a) (Type S. S. Sachder MD 126 A,	E trigh ST EE	Exton 1	10 21921						
Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature		/							
Registra	ar	SEP 2 1 2012 Januar B.	the way were								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 18, 2012 7:35 рм Charles Edward Muir Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil 21 Christopher Lane Warwick Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Year) 219-26-1426 Director 73 1 [X M 2 □ F 1938 Maryland 15. Usual Residence of Decede show je 1 end 2 should be filed within 72 hours efter death with the Maryland tof Health end Mental Hygiene. If Item 27 Is marked other then "neturel", or Items 23a or 28e-f shor or other treumetic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Cecil Warwick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 Christopher Lane U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 Tes 2 No Specify 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) one year Pastor Church of Jesus Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vernon Fuller Muir Helen Martha Yurek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Christopher Lane, Warwick, Maryland 21912 Cynthia Ann Bond (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 e
Department of H
Importent: If ite
eny injury or ot
once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State WEST, CHOTE PROHISHO 4 Donation 5 Other (Specify) 09/21/12 <u>l Colora. Marvland</u> Cemetery 21. Signature of Funeral Service License Lee A. Patterson & Son Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami ettending physician and for use as the burial-transit or Attending Physicien: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: . If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 1 Yes 2 No 9 Unknown certificate has been signed by the inector, page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🚺 No 1 Yes 2 No after death.

Director: After this certific d in by the funeral director. of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide To the Hospitel or Atte within 24 hours after der To the Funeral Director, completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie son who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, State Registrar

		1	For State Registrar	State of Mar	-	partment of e <i>rtificate of</i>		nd Mental Hy	giene Reg. No. 20	12 3216	
ı	Physicia Medic	n/	1. Decedent's Name (First, Middle, Last Jenny Ma					2. Date of Dea Month Septem	ath ber 18 201	3. Time of Death 07:12 PM	
	Examin		4a. Facility Name (if not institution, give s Smith Creek	street and number)		4b. City, Town	, or Location of I	Death	4c. County of Death Cecil		
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	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. It fitem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	irector	Usual Residence of Decedent	1	0c. City, Town o	rth East				10d. Inside City Limits 1 ☐ Yes 2 V No	
	h with the ns 23a or nust be r	Funeral D	691 Hances Point			10f. Zip Cod	21901	United S	States		
9800	within 72 hours after death with the Maryland gienn than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 □ Married 0 3★Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	er in U.S.	3. Was Decedent of If Yes, specify Control of Image 2 1		n? (Specify Yes or No- Puerto Rican, etc.)	5,000,0	merican Indian, /hite, etc. /hite	
215-0	hin 72 hou ne. <b>than "nat</b> u e Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	ucation de completed) College (1-4 or 5+)	(G	ecedent's Usual Occive kind of work dor e. DO NOT use retire	ne during most o ed)	f working	16b. Kind of Busine	ess Industry	
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Baltimore,	Page 1 and ment of Hea ant: If item ury or other		20a. Method of Disposition  1 Surial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State	20b Place of D Novertery	sposition (Name of	≝ede) Se	eptember	20c. Location - City	or Town, State	
Baltir	permit, Page Department of Important; If any injury or once.		21. Signal, re of the transfer ce licent		Method	st Cemeter 22. Name and Add	dress of Facility	Crouch Fund Street Nor	eral Home,	P.A. aryland 21901	
	'nysician/ Medical Examiner		23a. Part 1. Enter the disease, or camp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	lications that caused the cause on each line.  a	cer (	enter the mode of c	lying, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death	
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09	cate be executed physician and s the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a c	consequence of):						
Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at ti 9  Unknown	Fetal death	3			23d. Date of Month	f delivery Day Year	
ls, P.O.	uires that th n signed by ıld be detac	by	Part II. Other significant conditions co	entributing to death but	not resulting in t	he underlying cause	given in Part I.			e to the cause of death?	
Division of Vital Records, P.O.	sician: The law req s certificate has bee lirector, page 2 shoo	Completed						24a. Was auto perfo 1 \( \subseteq \text{Yes}	psv prior	e autopsy findings available to completion of cause of h? Yes 2  No	
Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 🗆 ER/Outp		Other	(Check only one)	dence 6 Other (S	lpecify)	
on of	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate: 7	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, 1	28b. Tin	ne of 28c. In	njury at vork? Yes 2 N	28d. Describe I	now injury occurred		
Divisi	ital or Atten ins after deat al Director: led in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (	Specify)			City or Tov	vn, State)	r Rural Route Number,	
	the Hospita nin 24 hours the Funeral npleted fillec	Medical	(Check 2 ☐ Medical Exami only one) 3 ☐ Certifying Nurs	sician: To the best of miner: On the basis of exa e Practioner: To the be	mination and/or i	nvestigation, in my o ge, death occurred a	pinion, death occ at the time, date a	urred at the time, date a	and place, and due to ne cause(s) and manne	the cause(s) and manner stated r as stated.	
	To the within 2 To the comple		29b. Signature and title of certifier	des-5 M	D		onse number 10 <i>2</i> 332	2	29d. Date signed (M 9. 19.		
			30. Name and address of person who o	ompleted cause of dea	th (Item 23a) (Ty	oe, Print)	- 11	· Mass	100 /		

Registrar DHMH 17 Rev 7/2009

State

			For State	State of I	-	epartment of l Certificate of l			7	012	32170	
			Registrar  1. Decedent's Name (First, Middle	e, Last)		Och timodic of t	Journ	2. Date of De			3. Time of Death	
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1	Examin	er	4a. Facility Name (if not institution				r Location of Death			unty of Death	20200	
7	Funeral		Doctor's Commu		Age (In yrs. last birth	Lanham  If Under 1 Year  Months Days		8. Date of Bir (Month, Da	th		lace (State or Foreign	
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	and show fat	rot	10a. State 10b. County		10c. City, Town	or Location	<u></u>	1 00/00/			0d. Inside City Limits	
	Mary 28a-f notifie	irec		e Georges	New C	arrollton					1 Yes 2 No	
	/ith the 23a or st be r	Funeral Director	10e. Street and Number	D 1 1.	m O	10f. Zip Code 20784			10g. Citizen	of What Coun	try?	
	death v	Fune	7745 Riverdal	12. Was Deceder	nt Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto			Race - Americ		
20	after o	d by	1 Never Married 2 Mar 3 Widowed 4 Divorced	rried 1 Mary 1 Yes 2 If Yes, Give	<sup>□</sup> № 1967 <b>–</b>	1 Yes 2 No		Thoun, otoly	Sper	Black, White, o		
9500-612	hours natura lical E	lete	15. Decede	ent's Education	16a.	Decedent's Usual Occup			16b. Kind o	Whi		
7	hin 72 ne. <b>than</b> "	Completed	Elementary/Secondary (0-12)	est grade completed)  College (1-4 of	or 5+)	(Give kind of work done life. DO NOT use retired)		ang			ernment	
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Maryland	d be fill	ပ္	Edward C. Mul	ligan			Dorothy	A. Car	ter			
/lan	should and I is ma		19a. Informant's Name/Relations			Mailing Address (Street					1	
e,	and 2 Health tem 2		Joanna Mulli 20a. Method of Disposition	gan / wite	20b. Place of	5 Riverdale Disposition (Name of		2 New		lton, I on - City or To		
ē	Page 1 nent of int: If i		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (		aic   .	y, crematory or other plant of the coln Cremat		0/2012		•		
saltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	. 4	21. Signature of Funeral Service	Licensee	.10	22. Name and Addre	ess of Facility ${ t Ft}$ .	Lincol	n Fune	ral Ho	me, Inc.	
_	0.0 <u>7</u> € 0		23a, Part 1. Enter the disease,	Complications that cau	sed the death. Do no	3401 Blade				, MD 2	0722 Approximate	
1	Ph_sician/		shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.	-					Interval Between Onset and Death	
	disease or condition resulting in death)  disease or condition resulting in death)  Due to (or as a consequence of):											
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	d d ansit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury										
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9	cate be physic s the b	edical		d								
200	certific anding use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		3 ☐ Ectopic pregnan	CV		23d.	. Date of delive	ery	
ROX	death the atte	/sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of death	5 Other (specify)				Month	Day Year	
л Э	hat the ed by t detach	y Ph	Part II. Other significant conditi	ons contributing to deat	th but not resulting in	the underlying cause g	iven in Part I.	23e. Did t	obacco use c	ontribute to th	ne cause of death?	
S, I	uires t in sign	ed by						1 🗆	Yes 2 □ N	lo 3 🗆 Prob	oably 4 Unknown	
Vital Records,	aw rec as bee	Completed	T					24a. Was auto	psy	prior to co	osy findings available mpletion of cause of	
Ž	r: The licate h		25. Was case referred to medical				10 11 10	1 \( \text{Yes}	2 No	death?	2 🗆 No	
VITa	ysiciar s certii directc	To Be	examiner?  1  Yes 2 No	Hospital:	patient 2 ER/Ou	Oth	lace of Death (Chec ner: 4 \sum Nursing He		dence 6 🗆 (	Other (Specify	)	
0	ng Phy fter thi uneral		27. Manner of Death 1 ☑ Natural 5 ☑ Pendi	28a. Date of	injury 28b. T	ime of 28c. Injury wor	ry at k?	28d. Describe				
Sion	ttendi death. stor: A y the fu	Certificate:	2 Accident Invest	igation I not be	Injuny - At home far	M 1	Yes 2 No	28f Location (	Street and Nu	umber or Rural	Route Number,	
DIVISION OF	al or A s after il Direct		4 ∐ Homicide determ		, etc. (Specify)	in, brook, lactory, omes		City or To		moor or rioral	, route manners,	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical	g Physician: To the best Examiner: On the basis of	of examination and/o	r investigation, in my opini	ion, death occurred a	at the time, date a	and place, and	d due to the car	use(s) and manner stated.	
	To the within To the comple	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)										
	-		Shots	est!		MDI	05467	5	09	1171	112	
	Sam		30. Name and address of person Shobhit Ator	`	of death (Item 23a) ( 1118 Good	) ). A	d. Lank	cem, n	100.	20706	0	
	Sta		31. Date filed (Month, Day, Year)	32. Regi	istrar's Signature	parke	,					
Zail.	Registr	air	3CF 8	A PAIR W		21						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Anthony Garland McNeal, Sr. 09 2012 5:30 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6006 Toby Drive Temple Hills Prince George's Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Hours **Director** 579-62-4221 1 👿 M 2 🗆 F 61 03/25/1951 DC Usual Residence of Decedent show with the Maryland ms 23a or 28a-f sho must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince George's Temple Hills 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6006 Toby 20748 Drive filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. ö ģ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Black al Hygiene. d other than "nature event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Supervisor Parker Mailing Company Warehouse Be Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nathaniel Isaac McNeal Sr. Emma Agnes Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Plummer-McNeal/Wife 6006 Toby Drive Temple Hills, MD 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemeter: 09/24/2012 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC CHOLANGIOCARCINOMA disease or condition MONTUS Medical resulting in death) Due to (or as a consequence of): Examiner 20 YEARS HEPATITIS Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery ĕ in the past 12 months? To the Hospital or Attending Physician: The law requires that the death Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? certificate 1 ☐ Yes 2 ☐ No 2 🗷 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2 X No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify, eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending **X** Natural injury work? 1 ☐ Yes 2 ☐ No after death ☐ Accident ☐ Suicide Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 1 🗟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie, 29c. License number 29d. Date signed (Month, Day, Year) M 064931 SSPREMBER, 19, 2012

55M

State

31. Date filed (Month, Day, Year)

COSHROVE, JOHNS HOPRINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MS 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \( \int \) for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 14, 4:15 P M 2012 MARVIE IOLA LEARY MELVIN Medical 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **OUEEN ANNE'S** HOSPICE OF QUEEN ANNE'S, **CENTREVILLE** INC If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) Social Security Number **Funeral** 1 M 2 X F Months Hours Min. MARYLAND 102 214-34-9009 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County at Director notified QUEEN ANNE'S GRASONVILLE 1 X Yes 2 No 28a-f MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'n must be Funeral 23a 21638 USA 3917 MAIN STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 No 9 be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: "natural", 3 X Widowed 4 Divorced WHITE Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) the FOOD SALES CLERK -0other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic ever ဂ OREGON C. LEARY LULA I. TARBELL and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM EUGENE MELVIN/ SON 326 DULIN CLARK ROAD, CENTREVILLE, MD 21617 Health tem 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State CHESTERFIELD CEMETERY CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Funeral Service P.A. P.A. Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Reverl trans and that initiated events Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? ło Month Dav Pregnant at time of death 2 🖪 No 9 Unknown should be detached 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 1 Yes 2 No this certificate Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital 4 Nursing Home 5 Residence 6 Other (Specify) Hognes Care 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending after death. Director: Af 1 Yes 2 No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 24 hours a Medical 29a. Certifier сопріете (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F

only one) 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARRABALTA MD.

Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

gh Street Chester four, Wed 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day 14, David W. McLoud Physician/ September 2012 4:00 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 3449 Hidden River View Road Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min (Month, Day, Year) 217-52-4509 61 Director 1 🔀 M 2 □ F June 27, 1951 Massachusetts Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director Anne Arundel Annapolis Maryland 1 🗌 Yes 2 🕱 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3449 Hidden River View Road 21403 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examino once. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: White If Yes, Give 1970–71 Year or Dates. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) General Supervisor Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles R. McLoud Joan Wonson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sallie McLoud/wife 3449 Hidden River View Road Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/20/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Baltimore Crematory Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Part 1. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Queet and Douth Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury igned by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Yes 2 No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No page 2 should within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital Other Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Ny rse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying 29d Da (Month, Day, Year) 29b. Sonatu 2 V lame and address of per 7+1 State SFP 2 0 2012 Registrar

			Charles	epartment of Health and	Mental Hygiene					
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2012 321/1					
J. P. San	Physicia Medic	al		DUALD	2. Date of Death Month Day Year 3. Time of Death S 3 M					
	Examin	ier	Anne Arundel Medical Center	4b. City, Town, or Location of Deat  Annapolis	4c. County of Death Anne Arundel					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda							
	Director		236-36-9383 Usual Residence of Decedent 1X M 2 □ F 84		7/29/1928 Maryland					
	land show d at	tor	10a. State 10b. County 10c. City, Town or	r Location	10d. Inside City Limits					
	Mary 28a-f	Director	3	dsonville	1 □ Yes 2 🛣 No					
	with the		10e. Street and Number 3532 Russell Thomas Lane	10f. Zip Code 21035	10g. Citizen of What Country? USA					
920	filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status  1 Never Married 2 M Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 M Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 X No Specify:	pecify Yes or Noto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White					
Baltimore, Maryland 21215-0036	thin 72 hour sne. than "natu ne Medical	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occupation ive kind of work done during most of wo e. DO NOT use retired)						
d 2	lled wi I Hygie other rent, th	Be	5+ years Pas 17. Father's Name (First, Middle, Last)	stor 18. Mother's Na	Christian Ministry  mme (First, Middle, Maiden Surname)					
ylar	should be filed n and Mental Hy 7 is marked oth raumatic event	은	Julian Edward McDonald	Hiawa	atha Duvall					
, Mar	nd 2 shou ealth and m 27 is m		Frances D. McDonald/ Wife 353		ural Route Number, City or Town, State, Zip Code) Ln., Davidsonville, MD 21035					
imore	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		1 X Burial 2 Cremation 3 Removal from State cemetery, o	sposition (Name of crematory or other place) on UMC Cem. 9/2	Date 20c. Location - City or Town, State 23/12 Lothian, MD					
Balt	permit. Departi Import any inji		21. Signatur of uneval Service Licensee		eorge P. Kalas Funeral Home nd Rd. Edgewater, MD 21037					
	Ph <sub>,</sub> sician Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	enter the mode of dying, such as cardiac	c or respiratory arrest, Approximate Interval Between Onset and Death					
**	ate be executed hysician and the burial-transit	Sequentially list conditions, if any, leading to immediate vause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Value of the pregnant at time of death   S   Other (specify)   Month   Day								
. Box 68760	ath certifica attending p for use as									
ls, P.O.	requires that the des been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the PARKINS WS OI SEASC	ne underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown					
Division of Vital Records,	sician: The law req certificate has bee lirector, page 2 shou	Completed by			24a. Was an autopsy performed?  1  Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No					
/ita	s certifi	To Be	25. Was case referred to medical examiner?  1  Yes  Hospital: 1  patient 2  ER/Outpa	26. Place of Death (Che						
n of \	ding Phys h. After this of funeral dii		27. Manner of Death  28a. Date of injury  28b. Time (Month, Day, Year)  28b. Time (Month, Day, Year)	e of 28c. Injury at work?	Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
ivisio	al or Attending Pl s after death. I Director, After the d in by the funera	Certificate:	2		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b	Medical	29a. Certifier (Check (Check only one) Certifying Physician: To the best of my knowledge, dea	vestigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s) and manner stated.					
_	To the within complete complet	_	29b. Signature and title of Sertifier	29c. License number	29d. Date signed (Month, Day, Year)					
	1,8,	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lou Lukas, M.D.  445 DefeaseH Marry Howells MD 24401								
	Ag x	1	130. Name and address of person who completed cause of death (Item 23a) (Type	e, Print) Lou Lukas, M.D.	4401					
Í	Stat Registra		31. Date filed (Month, Day, Year) SEP 2 0 2012 32. Registrar's Signature	back	, 91					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death RegistramenD#1perMD, 9/19/12; BMW, MbCb 1. Decedent's Name (First, Middle, Last) Michael MOSENKIS 2. Date of Death r 15, Physician/ 2012 September 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10716 Gainsborough Road Potomac Montgomery **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 070-64-7398 Hours Director 1 X M 2 □ F 57 Usual Residence of Decedent Dec. 14, 1954 Ukraine "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Montgomery Potomac 1 🗆 Yes 2 🖔 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10716 Gainsborough Road 20854 United States Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. white 3 Widowed 4 Divorced Specify: Completed of Health and Mental Hygiene.

item 27 is marked other than "natu
other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Physician Anesthesiology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Isaak Mosenkis Dora Dermer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10716 Gainsborough Rd., Potomac, MD Bella Mosenkis, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important; If ite any injury or of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Judean Memorial Gardens 09/16/12 4 ☐ Donation 5 ☐ Other (Specify) Olney, MD 21. Signature of Anera Servic Licensee Torchinsky Hebrew Funeral Home Part 1 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Gastric Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate

Cause (Disease or injury Due to (or as a consequence of) -transit and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Year signed by the a 1 | Yes 2 L 9 | Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Partial Small Bowel Obstruction Completed 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of Renal Failure 24a. Was an After this certificate has autopsy performed? Hypertension 1 ☐ Yes 2 ☐ No pletely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director, Algorithms for the funeral points of the funeral points death. Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Eertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 15, 2012 15 MD D 0055522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD Robert H. Gerard, M.D.,

State Registrar 31. Date filed (Month, Day, Year) **SEP 19 2012** 

Registrar's Signati

	•	Division of Vital Records, P.O. Box 687
		To the Hospital or Attending Physician: The law requires that the death certifica
F	Q	within 24 hours after death.
łе	gl	To the Funeral Director: After this certificate has been signed by the attending pl
gi	λ΄	completely filled in by the funeral director, page 2 should be detached for use as t

		For State Registrar	State	e of Ma	ıryland	-	rtment of I ificate of L		d Mental Hy		2012	2 32178
Physicia	n/	Decedent's Name (First, Middle	. ,	DOGDV		00/1	modito or i	Journ	2. Date of De		Year	3. Time of Death
Medic Examine	al	4a. Facility Name (if not institution					4b. City, Town, o	r Location of Dea		BER 19,	2012 nty of Death	
		RESIDENCE. 531				E	INDIAN	HEAD		СН	ARLES	
Funeral Director		5. Social Security Number 213–32–6424	6. Sex 1 □ M 2 □		(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	ay, Year)	Cour	**
nd how at	7	Usual Residence of Decedent  10a. State 10b. County				, Town or Loca	ation		CLIUBER	15, 1933		INGTON, D.C.
th the Maryland 3a or 28a-f show be notified at	Director	MARYLAND CHAR	LES		IND	IAN HE	AD					1 ☐ Yes 2 😿 No
vith the 23a or st be n	ralD	10e. Street and Number 5315 POSEY GRA	Y PLACE				10f. Zip Code <b>20640</b>	1		10g. Citizen e		*
death v items ier mu	Funeral	11. Marital Status	12. Was I	Decedent Ev				lispanic Origin? (	(Specify Yes or No- erto Rican, etc.)	14. F	Race - Ameri	can Indian,
s after ral", or Examin	ed by	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	rried 1 🗌 '	Yes 2 <b>X</b> N , Give or Dates.	No		☐ Yes 2 <b>X</b> No		,	Spec	Black, White,	ACK
72 hours n "natura fedical E	Completed	(Specify only high	ent's Education est grade comple	eted)		(Give ki	nt's Usual Occup nd of work done	during most of w	orking	16b. Kind o	f Business/Ir	ndustry
s filed within 72 houn tal Hygiene. ed other than "natu event, <u>the Medical</u>		12TH GRADE	Colleg	ge (1-4 or 5+	+)		NOT use retired) SIVES TE		N	FEDER	AL GO	VERNMENT
and 2 should be filed with of Health and Mental Hygien If item 27 is marked other the other traumatic event, the	To Be	17. Father's Name (First, Middle, CHARLES GRAY	Last)						lame (First, Middle BROWN GRA	•	ıme)	
should and M is ma raumat		19a. Informant's Name/Relations		GRAN	D-	_			Rural Route Numb			Code)
f Health		TIFFANY Y. WAS	HINGIUN/	DAUGH	20b. Pla	ace of Disposi	tion (Name of		CCOKEEK,	MARYLA 20c. Locatio		0607 Town, State
Page 1 ment of I tant: If its		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	Specify)	from State			tory or other place		T. 27,2012			
permit. Page Department o Important: If any injury or once.		21 Senature of Euneral Service	N JOHNSON	M0058	33	TH	Name and Addre	SS of Facility UNERAL	HOME, P.	A.	D MAI	RYLAND 20640
		23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications t	hat caused							D, MAI	Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a <u>C</u>	hron	ie	ohol	with	- Lung	Die	arl		Onset and Death
Examiner		Sequentially list conditions,	T b	e to (or as a	conseque	ence oi):	nce					
ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due Due	e to (or as a	conseque	ence of):	ese					
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sate be physici the bu	edical		d	art	en	osil	eras					
ath certifica attending p	an/M	IF FEMALE: 23b. Was decedent pregnant		, outcome o			Ectopic pregnanc	CV		23d.	Date of deliv	/ery
Attending Physician: The law requires that the death certificare death.  ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 🔲 1	Pregnant at Unknown			Other (specify) _				Month	Day Year
requires that the des been signed by the s should be detached		Part II. Other significant condition	ens contributing	to death bu	it not resu	liting in the un	derlying cause gi	ven in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
requires	Completed by	at it	- Syl	11-		-1	T /	nd				bably 4 Unknown
he law te has t age 2 s	omp	anemia,	aste	JAN C		in	un		24a. Was auto perf	opsy ormed?		opsy findings available ompletion of cause of
Physician: The law r this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:					lace of Death (Ch	1 \(\sum \) Yes heck only one)	2 <b>.K</b> No	i □ Yes	2 🗆 NO
g Physi er this c	e: To	1 ☐ Yes 2 🗶 No 27. Mapner of Death	28a. E	Date of injury	у :	ER/Outpatient 28b. Time of	28c. Injur	4 □ Nursing y at	Home 5 Resi	idence 6 C		(y)
tending death. tor: Aft the fur	Certificate:	1 A Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Coulc	igation	Month, Day,		injury		k? Yes 2 □ No				
al or At s after ( al Direc ed in by	_	4  Homicide deterr		lace of Injur uilding, etc.			et, factory, office		28f. Location ( City or To		nber or Rura	al Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medica	(Check 2 Medical	Examiner: On the	e basis of exa	amination	and/or investig	gation, in my opini	on, death occurre	e, and due to the ced at the time, date d place, and due to	and place, and	due to the ca	ause(s) and manner stated.
To the vithir comp	2	29h Signature and title of certifie				· · · · · · · · · · · · · · · · · · ·	29c. Licens		piace, and due to	29d. Date sig	ned (Month,	Day, Year)
12		30. Name and address of person					D 08	370		SEPTEM	BER 2	1, 2012
Bry,		PAUL E. PRITCH	ETT, SR.	, M.D	. 11	8 LA G		ENUE, L	A PLATA,	MARYLA	ND 206	546
Stat Registra		31. Date filed (Month, Day, Year) SEP 2	L 2012	32 Aegistrar	's Signatu	1. pa	Nes!					
			-			-						

12-07139 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anthony J. Perry State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 21, 2012 Medical Examiner Anthony James Perry 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 30295 Summitt Court Mechanicsville St. Mary's 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months Director 1 **▼**M 2 F Yrs 48 06/24/1964 213-98-0762 Usual Residence of Decedent 10b. County 10c. City, Town or Location s 23a nr 28a-f show a notified at once. Baltimore, MD 21213-0030
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a nr 28a-f sht injury or other traumatic event, the Medical Examiner must be notified at once St. Mary's Mechanicsville Director 10g. Citizen of What Country? 10e. Street and Number 30295 Summitt Court 20659 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married If Yes, Give Year 4 X Divorced Yes 2 X No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sal<u>esman</u> 17. Father's Name (First, Middle, Last) 8 Louis Joseph Perry 19a. Informant's Name/Relationship (Type, Print) Sieglinde Wagoner 6605 Horseshoe Rd., Clinton, 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date crematory or other place) Burial 2 X Cremation 3 Removal from State Donation 5 Other Specify 21. Signature of Furieral Service Licenses 44 #M00817 **Physician** failure vist only one cause on each line. /Medical a. Intraoral gunshot wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED e attending physician for use as the burial -IF FEMALE 23c. If yes, outcome of pregnancy . Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth 2 Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be Completed 24a. Was an autopsy performed? ✓ Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) 8 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ဥ No

14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Auto Sales 18. Mother's Name (First, Middle, Maiden Surname) <u>Sieglinde Wagoner</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD20c. Location - City or Town, State Brinsfield-Echols Crem 09/24/2012 Charlotte Hall, MD 22 Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Road, Charlotte Hall, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and of Vital Records, P.O. Box 68760, 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗸 Yes Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject shot self Natural FOUND: 1 Yes 2 ✔ No 5 Pending the Sep 21, 2012 1841 hrs 2 \_\_\_ Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 30295 Summitt Court, Mechanicsville, MD determined (Specify) Single Family Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 22, 2012 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. 32 Registrar's Signatur State Registra **ORIGINAL** DOME

2012 321

1841 hrs

Country) Maryland

10d. Inside City Limits

1 Yes 2 X No

Year

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Sept 19 1:35p M Georgia Plummer Pusey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 197 Love Run Road Colora Cecil 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours Director 212-16-5693 1 🗆 M 2 🗆 F 5/4/1920 92 NC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 28a-f 1 Yes 2 No MD Cecil Colora 10f. Zip Code ö 10e. Street and Numbe 10g Citizen of What Country? 23a Funeral 197 Love Run Road 21917 USA or items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 ☐ Yes 2 ☐XNo If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 'natural", Completed Specify: White 3 
Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hvillimportant if item 27 is many injury or other. Beautician Owner/Beauty Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Seibert Plummer Mamie Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Lucas/ Sister 830 Little New York Rd. Rising Sün, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20c. Location - City or Town, State 21/12 me, P ☐ Burial 2X Cremation 3 ☐ Removal from State Foard Funeral 4 Donation 5 Other (Specify) Home, Rising Sun, MD neral Service Licen R.T. Foard Funeral Home, P.A. Oueen St. Rising Sun. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph. i. i.an disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MYELOMONOCYTIC LEUKEMIA Sequentially list conditions Examine cause (Disease or injury Due to for as a conseque burial-transit The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 Yes been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has page 2 autonsy perfor death? 1 Yes 2 No Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other 은 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify, Manner of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

5

ROBERT

31. Date filed

cause of death (Item 23a) (Type, Print)

Registral's Signature

E. MAIN

MD 0066323

20

SUN, MD

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 17, 2012 2012 1327  $P_M$ Eula B. Powell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 224-46-1848 81 Director 1 □ M 2 🛣 F Aug. 23, 1931 Virginia 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Takoma Park Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7511 Dundalk Road 20912 USA death v "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2X No be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Completed 3 X Widowed 4 □ Divorced Black Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Media Specialist Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ဂ Ulvsses Simpson Burwell Sallie Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7511 Dundulk Rd., Takoma Park, MD 20912 Page 1 and 2 st tment of Health a tant: If item 27 is Carole L. Walker - daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State injury or 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Department of Important: If any injury or Parklawn Memorial pk. 9/27/12 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. K. Johnson Funeral Home, P. A 6503 Old Branch Ave., Temple Hills, MD 20748 art 1. Enter the disease, or co hock, or heart failure. List only nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition as a consequence of): Medical resulting in death) Examiner Cardiomyopathy Sequentially list conditions, Examine Due to (or as a consequence oi). n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Pneumonia requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No the detached 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law certificate has performed 2 🗆 No 1 Yes Yes 2 No s after death.

I Director: After this certification by the funeral director, Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending Accident М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined hours after To the Hospital within 24 hours a To the Funeral I Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D0055148 9/17/2012 on who completed cause of death (Item 23a) (Type, Print) Delroy Anglin, MD 1500 Forest Glen Rd., Silver Spring, MD 20910 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 17, Physician/ Carolyn Jean Pappamihiel 2012 10:56PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Social Security Number 8. Date of Birth (Month, Day, Year) Director 579-54-3739 1 M 2 X F 71 9/7/1941 Washington, DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Anne Arundel 1 Yes 2 No Maryland West River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20778 USA 1129 Cherry Point Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decessor.
Armed Forces?
1 Yes 2 No
If Yes, Give 14. Race - American Indian, Black White etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Assisted Living President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Estelle Loveless Lonnie Edward Polson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1129 Cherry Point Rd., West River, MD 20778 John Kevin Kilrov/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 9/24/12 Suitland, Maryland 4 Donation 5 Other (Specify) 21. Signatura Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Myocardial Infarction hour Medical Due to (or as a consequence of): Examiner Coronary Artery Disease 10 years Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transif Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 X No 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 1 ∐ Yes 2 2 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Pulmonary Disease 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🏋 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 X ER/Outpatient 3 I DOA completely filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

wa

Wayne Bierbaum, M.D. 134 Owensville Road, West River, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 2 0 2012

31. Date filed (Month, Day, Year)

D38563

September 18, 2012

20778

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ sept.17 ,<sup>Day</sup> 2012 Carmel Purification 0510 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1/01/1967 Director 220-81-6707 1 🗆 M 2 🔀 F 45 Bangladesh r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Md Montgomery 1 Yes 2X No 10e. Street and Numbe 10g. Citizen of What Country? 927 Northampton Drive Apt.F 20903 Bangladesh 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Never Married 2 😾 Married þ 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Asian Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Is marked o ပ္ Patrick Purification Palma Shanti 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co440 20903 f Health Michael Napoleon Gomes/ 927 Northampton Drive Apt.F Silver Spring, injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 9/21/2012 Silver Spring, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature uneral Service Lices PANTIP APPER TWALDI FUNERAL SERVICE, P.A. <u>9241 Columbia Blvd.Silver Spring,Md20910</u> 23a. Part 1. Enter the sease, or complications that caused shock, or heart ailure. List only one cause on each line. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ Onset and Death End stage liver cirrosis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and is the burial to the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) Dav 9 Unknown P.0. signed del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? ۾| Records. Completed 1 Yes 2 No 3 Probably 4 TyUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s 1 ☐ Yes 2 ☐ No ☐ Yes 2 🛣 No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: စ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titlero 29c. License number 29d. Date signed (Month, Day, Year) D73240 Sept.17,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd Silver Spring, Md Anisha Kumar MD

Registrar

31. Date filed (Month, Day, Year)

1 9 2012

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Stephen	George	Riley, III	
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		1- For State Registrar		Cer	tificate of	Death			F	teg. No.	01	
Physicia	in/	1. Decedent's Name (First, Middl	le,Last)						Date of Dea Month	ath Day Yea		. Time of Death
Medical Exami	ner	Stephen	George		Ley, III				Septemb	er 24, 2012		1654 hrs
		4a. Facility Name (if not institutio MD Route 234 Budd's	-	oer)	4	b. City, Town, Mechanic	sville			4c. County of St. Mary	s	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	st birthday)	If Under 1 \	ear If Und			rth (MM/DD/YYYY)	Foreign	
Director		035-36-2714	1 <b>X</b> M 2 F	60	Yrs.	MOTITIS	lays Hours	S IVIII.	09/0	3/1952	Coun	ry)New York
any		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Location	on					11	Od. Inside City Limits
<b>*</b>	_	· ·	. Mary's	,	Mechan		1e					Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number				10f. Zip Code	9		1	log. Citizen of Wh	at Country	P
h the l		42329 Brook M	lanor Road			2	0659			US	A	
tems 2	Funeral	11. Marital Status  1 Never Married 2 X Ma	12. Was Deced arried Armed Force			Decedent of s, specify Cul				o- 14. Race - White		n Indian, Black,
ter dez			1 X Yes	2 No	1 1	Yes 2 🕱	No specify:	:		Specify:	Whi	te
ours af	d b	15. Decedent's Education (Spec	or Dates:	completed)	16a. Decedent	s Usual Occu	pation (Give	kind of work		16b. Kind of Bus		
6 1.72 hc	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	_	st of working						viation
Within within Medi	E	AT Falled Many (First Mills	5+		Air Tr	affic				Admin:		tion
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural?, or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be C	17. Father's Name (First, Middle, Stephen Geo	,	y, Jr.			18.Mother	,		Maiden Surname) <b>Ruh</b>		
212 212 Ment Ment	2	19a. Informant's Name/Relations		,,	19b. Mailing	Address (St				nber, City or Town	, State, Z	ip Code)
MD d 2 sho Ith and n 27 is		Sharon Kay Ril	ley/Wife		42329	Brook	Manor	Rd.,	Mech	anicsvil	le, M	D 20659
re, s l and f Heal f item		20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal from	State Cr	lace of Disposit rematory or other	er place)		D	ate	20c. Location -	City or To	wn, State
Pager Pager nent o		4 Donation 5 Other Sp	pecify:	ma	ttingley ral Home.	, PA, Cr	ematory		8/2012			_
Baltimore, permit. Pages I ar Department of Hee Important: If ite	Ī	21. Signature of Funeral Service	Licensee	0.	22. Na	me and Addr	ess of Facility Ley-Ga	rdine	r Fune	ral home	, P.	Α.
Physician	-1	23a. Part/I. Enter the disease, or	complications/that caus	olleged the death.	7 4	<u>1590 F</u> €	<u>enwick</u>	ST.,	Leona	irdtown,	MD 2	0650 Approximate Interval
/Medical	Į	failure. List only one cause	on each line.				.9,		opilatory air	000, 0110014 01 1100		Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co		:							
		Sequentially list conditions,	b									
	Ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence of)	:							
git d	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of)	:							
an Scu		LINDENDED	d									
ce be e	n/Medical	UNPENDED  IF FEMALE:	AMENDED 23c, If yes, out	of						23d. Date of c	I alice and	
Box 68760, te death certificate be extending physician the attending physician ted for use as the burial	Na Na	23b. Was decedent pregnant in the past 12 months?		, ,	•	death	BEctopic	c pregnancy	,	Month	Day	Year
Box 68 e death certi the attendin ed for use a	Physicia		4 Pregnant	at time of dea	th 5 Othe	er (Specify)				1		
	튑	Part II. Other significant conditi			sulting in the un	derlying caus	e given in Pa	art I.	23e. Did to	obacco use contrib	oute to the	cause of death?
, P.O. res that the signed by be detach	2								1 Yes	2 <b>✓</b> No 3	Probabl	y 4 Unknown
of Vital Records, ng Physician: The law require Wher this certificate has been si neral director, page 2 should b	Completed							- 17	24a. Was			sy findings available
e law te has ge 2 sl	틸	·							autop perfo 1 Yes	rm <u>ed</u> ? de	eath? Yes	pletion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical				26. Pla	ce of Death	(Check only		2 10 1	Viles	2 140
Vita hysicia I direc	o Be	examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpa	atient 2 🗌 E	R/Outpatient	3 DOA	Other <sub>4</sub>	Nursing H	ome 5	Residence 6	Other: So	ene
ding Ph	٦	27. Manner of Death  1 Natural 5 Death	28a. Date of I (Month, Da Sep 24, 20	njury x.Year)	28b. Time of Inj UNKNOWN	· 1 _	jury at Work	lDri		now injury occurre		
SiOr httend death. ctor:	ăţ	Pendi	tigation				Yes 2 ✔	No				
Division pital or Attendi	Certification:	deten	not be	lajor Road	ne, farm, street,	factory, office	e building, et		or Town, S	tate)		Route Number, City echanicsville, MD
Iospit 4 hour		4 Homicide  29a. Certifier 1 Certifying Ph	ysician: To the best of			ed at the time	date and pla					echanicsvine, IVID
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical	(Circuit Griff)	niner: On the basis of e	xamination and								ause(s)
F.2 F.8	\$	29b. Signature and title of certifier				29c. Lice	nse number			29d. Date signed	d (Month,	Day, Year)
		レーシー	•			0.0	C.M.E.			September :	25, 201	2
sh	ľ	30. Name and address of person				V D-IE	Ct 1	Delti-	- MD 01	222		
		Donna M. Vincenti, MD  31. Date filed (Month, Day, Year)		dical Exami trar's Signature		V. Baltimo	re Street,	Baitimore	е, мо 21	<b>2</b> 23		
Sta Regist	110	ST. Date filed (Month, Day, Year)			back							
DHMH 17 Rev 1/20	01	021 0 0 2	012		ORIGINAL							•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Month 19, Sept. 02:05 A M Franceine Reddon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 435-52-4526 Usual Residence of Deced 1 □ M 2 🖺 E 74 1938 Louisiana ?7 is merked other then "naturel", or Items 23e or 28a-f ehow treumetic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No Clinton Maryland | Prince George's 10f. Zip Code 10g. Citizen of What Country? by Funeral 20735 United States 8904 Clayton Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 is nend Mentel Hyglene.
7 is merked other then "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Culinary Specialist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heelth and Mente Importent; if item 27 is merked , eny injury or other treument ဂ္ Allie Mae Hogan Herman Jefferson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 Ronald Reddon - Son 11405 Cheryl Drive Upper Marlboro, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Maryland
Veterans Cemetery 20c. Location - City or Town, State Sept. Date 26. 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Cheltenham, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. T. Stewar Solm 20019 4001 Benning Road NE Washington, DC M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final SEPSIS Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ettending physicien end I for use as the burlei-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Day signed by the et id be deteched fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2-☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No မှ Other: 1. Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deeth.

To the Funerel Director: After this completely filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospitei or Attending 24 hours after deeth. 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Vithin 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Qay, Year) D006363 SISPALL ZJW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiruy Bishaw, MD 5601 Toch Raven Boulvard Baltimore, Maryland 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 98 AMERICA Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per FH G932 10/05/2012 Jh State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09/17 2012 a 12:44A M Adela Reyes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hyattsville Prince Georges 2303 Banning Place 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Director 213-15-3248 1 M 2 X F 86 03/13/1926 El Salvador show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hyattsville "natural", or items 23a or 28a-f s edical Examiner must be notified MD Prince Georges 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20783 Salvador 2303 Banning Place Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 🖁 Yes 2 🗆 No Specify: Salvadoran Specify: White If Yes. Give 3 Widowed 4 ☐ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Asuncion Reyes Margarita Reyes traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, item 27 i 2303 Banning Pl., Hyattsville, MD 20783 Julio Fuentes-son or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State George Washington 9/22/2012 Adelphi, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home wandac. Bucon CC0361 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 972012th Immediate Cause (Final Ph\_sician/ Non-ST elevation miocardial infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 7/2000 Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of Hypercholesterolemia 7/1999 and Due to (or as a consequence of) resulting in death) Last attending physician use as the bur Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes You No
9 Unknown ate has been signed by the atte page 2 should be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s prior to completion of cause of death? 1 Yes 2 No Yes 2 X No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 \( \sum \) Yes 2 \( \sum \) No Hospital Other: ြုင 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Mi mil 9/17/12

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abby Miller,

MD 110 Irving St., NW Washington,

DC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day PATRICK JOHN. STEWART Medical entem 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death YENINSULA AICOMICO 50415641 Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex If Under 1 Year Funeral 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days Director 221-52-8106 1 **X** M 2 □ F 51 AUG 24,1961 MARYLAND item 27 is marked other then "netural", or items 23e or 28a-f sho other treumatic event, the Medical Examiner must be notified at 28a-f shov flled within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No DELAWARE SUSSEX COUNTY LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27191 KAYE ROAD 19956 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GRAIN OPERATOR AGRICULTURE PRODUCTS 10 Be 17. Father's Name (First, Middle, Last) permit. Pege 1 end 2 should be filed Depertment of Health and Mental Hy Importent: If item 27 is marked other prinjuy or other treumatic evenonos. 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ WILLIAM ROBERT **STEWART** RUTH COOPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30872 WHITE OAK ROAD, DAGSBORO, DELAWARE 19939 MISTY TOOMEY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1ST STATE CREMATORY SEP 20,2012 MILLSBORO, DE 19966 Signature of Longon Service License 22. Name and Address of Facility MO 1361 WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hepatic encophalopathy Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a conscouence of: use as the burlal-transit Hospital or Attending Physicien: The law requires that the death certificete be executed the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be deteched for I in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 G 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multiorgan dysfunction syndrome 2 No 3 Probably 4 Unknown 1 Yes Ventilator dependent respiratory failure 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Methicillin Resistant Staphylococcus aureus 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Mannes of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) mosha Peters-Itario mo 0007096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAY QUE CARROLL ST Salisbury MD 21801 Peters arris 31. Date filed (Month, Day, Year) SEP 2 State 0 201 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hyg  1 - State State Certificate of Death  Repuisitar	2012 22186
Dharia	/	1. Decedent's Name (First, Middle, Last)  2. Date of Deat	th 3. Time of Death
Physic Med	lical	5a1	per 16, 2012 11:50 AM
Exam	iner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death  Bowie Health Center  Bowie	4c. County of Death Prince George's
Funera Directo	_	5. Social Security Number 209-14-1111 6. Sex 7. Age (In yrs. last birthday) 1 Gunder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month) Month Min. (Month) Month Min. (Month) Month Min. (Month) Month Month Min. (Month) Month Min. (Month) Month Min. (Month) Month Month Min. (Month) Month Month Min. (Month) Month Mo	Year) Country)
3		Usual Residence of Decedent June 10	
aryland ta-f sho ified at	ector	10a. State   10b. County   10c. City, Town or Location   Bowie   10c. City, Town or Location	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the M a or 28 be not	i Dig	10e. Street and Number	10g. Citizen of What Country?
(and 21213-0036)  be filed within 72 hours after death with the Maryland antal Hygiene.  ked other than "natural", or items 23a or 28a-f show c event, the Medical Examiner must be notified at.	Funeral Director	3850 Enfield Chase Court, #213 20716  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	USA  14. Race - American Indian,
ster de ", or ite	þ	1 Never Married 2 Married 1 Yes 2 No	Black, White, etc.  Specify: White
hours a	leted	3 Widowed 4 Divorced Year or Dates.  15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
Z1Z15-UU36 within 72 hours after giene. er than "natural", o	dwo	3 Widowed 4 Divorced Year or Dates.  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12    College (1-4 or 5+)   College (1-4 or 5	Own Home
led wit Hygie other	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Name (First, Middl	flaiden Surname)
Maryland 2 should be filed Ith and Mental Hy 27 is marked off traumatic even	2	Joseph Knipp Isabelle Raffer	ty
nore, Marylal age 1 and 2 should be nt of Health and Ment t. If item 27 is marker v or other traumatic e		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number,  19b. Mailing Address (Street and Number or Rural Route Number,  6104 Arbor Street, Cheverly,	
of Heal		20a. Method of Disposition 20b. Place of Disposition (Name of Date	20c. Location - City or Town, State
t: Pg	.1	4 Donation 5 Other (Specify)  Maryland Veterans Cemetery 9/24/2012	Crownsville, Maryland
Departiment of the policy of t	200	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Gasch's Funeral Home, P.A.	4739 Baltimore Avenue Hyattsville, MD 20781
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre shock, or heart failure. List only one cause on each line.	Interval Between
Physician Medica	-	Immediate Cause (Final disease or condition resulting in death)  Multiple Trauma due to impact from Car  Due to (or as a consequence of):	Onset and Death
Examine		Depressed Skull Fracture	Mator
ed nsit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Crushed Chest  Due to (or as a consequence of):  Due to (or as a consequence of):	1 597
be executed sician and burial-transi	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):	100
5 e 5 e	edical	Internal Bleeding	
certification of the second of	Physician/Me	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	23d. Date of delivery
Hecords, P.O. BOX The law requires that the death cate has been signed by the atterpage 2 should be detached for upon the control of the cont	ysici	in the past 12 months?  1	Month Day Year
that the	by Ph		pacco use contribute to the cause of death?
rdS, equires een sig			es 2 🛮 No 3 🗆 Probably 4 🗀 Unknown
VItal Kecords, ysician: The law requires is certificate has been sig director, page 2 should b	Completed	24a. Was an autops perform	prior to completion of cause of death?
Cal H Sian: Th Pertificat Sctor, pa	BeC	25. Was case referred to medical examiner?	2 🖾 No
OT VIII ng Physic ter this conneral dire	은	POSPITAL: 1 Inpatient 2 X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Reside	ence 6 Other (Specify)
OD C ending eath. or: Afte	Certificate:	1   Natural   5   Pending   (Month, Day, Year)   injury   work?   Run over   2   Accident   Investigation   9/16/2012   11:30 AM   1   Yes 2   No   Run over	r by her own car
<b>DIVISION</b> tal or Attendir rs after death. al Director: Af	Certi	3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  St. Andrew's Catholic Church Parking Lot  28f. Location (St. City or Town 1940 Mitch	reet and Number or Rural Route Number, n, State) nellville Rd., Bowie,MD 20716
DIVISION OF VITAL To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cau	use(s) and manner as stated.
the H thin 24 the Fu	Me		
₩ % E %		Paul Oleonar Cyces D0031817	9/18/2012
5 Th		30. Name and address of person who completed cause of coath (Item 23a) (Type, Print)	rn 20716
Si	ate	Paul Thomas Lyons, M.D., 15001 Health Center Drive, Bowie, Mete 31. Date filed (Month, Day, Year) 2012 32 registrar's Signature	ID 20/10
Regist		ar SEF BULDIE A	

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 5:25 PM carano Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MedStar Har bor timore Baltimore City Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. (Month, Day, Year) Hours Director 1 X M 2 D F 220-38-2766 02-15-1942 Usual Residence of Decedent Washington, DC 70 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show inportant: other traumatic event, the Medical Examiner must be notified at any injury or other traumatic. 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No Baltimore City Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with <sup>1</sup> тепt of Health and Mental Hygiene. 1054 Bristol Place 21225 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 A Divorced If Yes, Give Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Private Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Catherine Read Charles Scarano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Juniper Court Glen Burnie, MD 21060 Michael Scarano/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 09-14-2012 Brentwood, MD 4 Donation 5 Other (Specify) Ft.Lincoln Cemetery Signature of meral Service I 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Ph, sician/ Coronary disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to Number consequence of Hospital or Attending Physician: The law requires that the death certificate be executed OPD and the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year the 9 Unknown 9 Unknown signed by Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Perphenal vascular 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To bacces 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 2 UN 2 No Yes 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and D6084Z 55M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Hanover State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Year LEE DIPNSON 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Burtonsville The Sanctuary at Holy Cross If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Hours 82 577-44-4758 Director 1 □ M 2 🗓 F June 12, 1930 West Virginia Usual Residence of Decedent or 28a-f show a notified at 10c. City, Town or Location Director 1 ☐ Yes 2 X No Maryland Prince George's Upper Marlboro 10e. Street and Number or 10g. Citizen of What Country? items 23a or ner must be n Funeral 9609 Tam O Shanter Drive 20772 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner or þ 1 Never Married 2 X Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Completed 3 Divorced 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Home vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dolan Wright Goldie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George W. Stevenson, Sr./Hus. 9609 Tam O Shanter Dr., Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 9/20/12 Edgewater, MD injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Jan Solvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death FREBRO VASCOLLAR ATHEROSCLEROTIC Ph\_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that the death certificate be executed that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed Yes 2 death? No No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one 1 Yes Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 27. May of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. Il Director: Aft ed in by the fu 2 Accident 1 Yes Investigation Could not be 2 🗌 No Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after
To the Funeral Directory City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 28895 mi lelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AICHAMI, OWINGS MILL MD 21117 1525 P-D DOY 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a.pt.1,28a-f,per me,g932 10-23-12 sm State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept 15, Teresa M. Thomas 2012 4:30 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Months Hours Min (Month, Day, Year) 222 20 7150 **Director** 1 □ M 2 XX F 76 Oct 25, 1935 Delaware 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 TyNo Maryland Charles Waldorf 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be 23a ( Completed by Funeral death with 6085 Thorobread Court Apt C 20603 United States ral", or items a 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur Episcopo Margaret Sheehan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Thomas (son) 7127 Park Terrace Drive, Alexandria, Va 22307 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licensee Clinton, MD 20735 14101549 Ferry Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Choling** Approximate Interval Betweer Immediate Cause (Final ALUTE Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a conseq **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on burial-trans resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Pregnant at time of death 5 Other (specify) Month Day Year be detached 9 Unknown 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 X Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred subject choked on bolus of those on a piece of meat food within 24 hours after death.

To the Funeral Oirector: After Unk P. M 5 Pending ☐ Natural Division 2 Accident Sept. 15 2012 Afternoon 128e. Hace of njury - At home, farm, street, factory, office building, etc. (Specify)
Longhorn Steak House Home Investigation Afternoon Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide Location (Street and Number of Flural Flouts Numbered Ct. City or Town, State 0335 Thorong Tibered Ct. Waldorf, MD filled in by Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

2012

UNECHNER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 314 M Physician/ 2012 09 Beatrice Thompson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital <u>Takoma Park</u> 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday, **Funeral** Min. (Month, Day, Year) Hours 1 🗌 M 2 🏝 F 577-66-9967 Director Washington, DC 02/10/1951 61 Usual Residence of Decede 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State death with the Maryland Funeral Director notified 1 Yes 2 No Washington DC 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ö ms 23a or must be r 20017 USA 5101 Sargeant Road, NE unit 311 th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 is marked other the any injury or other traumany. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Specify. Completed 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry Accountant 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Naomi Miller Lawrence Stroman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sargeant Road, NE #311 Washington, DC 20017 Tyrone Thompson - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 09/24/2012 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc 21. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Eber the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final artmoselaic heart Dision Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s 1 Yes 2 No 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie completely within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 676/3 Kame D.O 25.M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Liber Fanne 7400 (arroll Att, Takoma Park, MD

Registrar DHMH 17 Rev 06-2011

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylan  State of Marylan  State of Marylan		artment of F <i>tificate of L</i>				012	32191
			Registra MEND#20loperFH, 9/19/12; BMW, MoC 1. Decedent's Name (First, Middle, Last)	) Cer	uncate of L	)eau i	2. Date of De	Reg. No.		3. Time of Death
-	Physicia Medio	al	ANNA B. TYSON				Septem	ber 13,	2012	1:15 PM
	Examir	er	4a. Facility Name (if not institution, give street and number)  Laurel Regional Hospital		1	Location of Death	•	4c. County		George's
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. 1	-,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	th		ice (State or Foreign
	Director §		Usual Residence of Decedent	Yrs.			AUG 1	1940	INDI	ANA
	a-f sho	ctor	10a. State	ity, Town or Lo	ER SPRI	NIC.			100	d. Inside City Limits
	the Ma or 28g	Dire	10e. Street and Number	2111	10f. Zip Code	NG .		10g. Citizen of	What Country	
	th with ns 23a must b	<b>Funeral Director</b>	9405 SIERRA STREET			903		U	SA	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Bla	ce - Americar ck, White, etc LACK	
15-0	72 hou n "natu fledica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa	uring most of worki	ng	16b. Kind of B	usiness/Indu	stry
212	within giene. ner tha t, the N	Cor	Elementary/Secondary (0-12) College (1-4 or 5+)	ADMIN	IISTRATI	VE ASSI	STANT	PRIV	ATE	
yland	ld be filed Mental Hy larked ott	To Be	17. Father's Name (First, Middle, Last) LESLIE E. CALDWELL			18. Mother's Name	R HUGL		e)	
Mar	12 shoualth and 27 is m		19a. Informant's Name/Relationship (Type, Print) ALBERT TYSON JR/HUSBAND			nd Number or Rura				
Baltimore, Maryland 21215-0036	Page 1 and ment of Hes ant: If item ury or othe		20a Method of Disposition	Proper gren	Manoria Washire Tery	I Park TON 9/21	) ate / 12	20c. Location	,	n, State
Balt	permit. Departi Import any inj		21. Signaure of Funeral Service Licensee CC052	22	. Name and Addres	-	l4th S	T NW W	ASH I	C 20010
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to r as a consecution resulting in death)	quence of):			r respiratory arr	rest,	li C	opproximate Interval Between Inset and Death Dct y S
		iner	Sequentially list conditions, if any, leading to firm adult cause. Enter Underlying	imbrar Juence St;	nous Co	PIITIS				WeeKs
	Band and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	15plas	id					WeeKs
092	te be ex tysician ne buria	edical	d. Hyperten							Years
Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and sompletely filled in by the funeral director, page 2 should be detached for use as the burnal the solutions.	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant in the past 12 months? 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗀	Ectopic pregnanc Other (specify)	у			te of delivery	
P.O	s that t gned b be deta		Part II. Other significant conditions contributing to death but not re					bacco use cont		
ords	require been s should	leted	Anemia, Thrombocytopenia Obesity, Renal Failure	L, Nes	piratory	Failure,	24a. Was a			bly 4  Unknown
Rec	sician: The law certificate has k lirector, page 2 s	Completed by	Obesity, Nenat Tallare				autop perfo	osy		pletion of cause of
/Ita	ysician: is certifica director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  1 Inpatient 2	TD/0.44:	Othe	ce of Death (Check				
n of	iding Phy th. After this funeral o		27. Manuer of Death 1	28b. Time of injury	28c. Injury work	4 \ Nursing Hor at Yes 2 \ No		ow injury occurr		
Division of Vital	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After thin the Funeral Director After the Completely filled in by the funeral Director.	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specification of the country				28f. Location (S City or Tow	treet and Numb n, State)	er or Rural Ro	oute Number,
_	ne Hospiti in 24 hour ne Funera pletely fille	Medical	29a. Certifler (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination only one)  3 Certifying Nurse Practitioner: To the best of	n and/or investi	igation, in my opinio	n, death occurred at	the time, date a	nd place, and due	e to the cause	e(s) and manner stated.
	within Post	_ ,	29b. Signature and title of certifier		29c. License			29d. Date signed		,
			30. Name and address of person who completed cause of death (Iter	n 23a) (Type, P	rint)	8998		Septer	mber.	14, 2012
			Pritam S. Saini, MD 9101 Cher 31. Date filed (Month, Day, Year) 32. Registrar's Signa	ry Lai	ne, Suite	211 L	aurel,	MD 2	0708	
	Stat Registra	9	31. Date filed (Month, Day, Year)  SFP 19 2012	bar bar	Ked.					

12-07279 A'miyah Watkins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certificate of	f Death		Re	eg. No. 2	3219		
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) A'Miyah Jo'Le'	Watkins	-			2. Date of Deal	th Day Year er 26, 2012	3. Time of Death 0906 hrs		
}		4a. Facility Name (if not institution, give			4b. City, Town,	or Location of [		4c. County of			
<i></i>		Bowie Health Center	17.4		Bowie	I Mala des	Miles To Date (18)	Prince Ge			
Funeral Director			√. Age (in	yrs. last birthday) Yrs	Months D	ear If Under 2 ays Hours	Min	15			
any		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Locat	ion			-	10d. Inside City Limits		
<b>≜</b> .,	5	MD Prince Ge	orge's	Bowie					1 X Yes 2 No		
with the Maryland ms 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 15803 Anthony V	√ay		10f. Zip Code 207		11	10g. Citizen of What Country? USA			
WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", nr items 23s or 28s-f shomatic event, the Medical Examiner, must be notified at once	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin?) (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 16. Was Decedent of Hispanic Origin?) (Sp. 17. Was Decedent of Hispanic Origin?) (Sp. 18. Was Decedent of							- 14. Race - White, Specify:	American Indian, Black, etc.  Black		
136 hin 72 hours a te. than "natura edical Examin	ompleted by	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	chighest grade complete College (1-4 or 5+)			pation (Give kin ife. DO NOT us		16b. Kind of Busi			
5-0036 led within 72 ho Hygiene. I other than "no the Medical Es	omo	0 17. Father's Name (First, Middle, Last)				18.Mother's	Name (First, Middle, M	·			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	James Gilbert					Watkins	,			
imore, MD 21215-003 Pages I and 2 should be filed withinment of Health and Mental Hygiene. Itant: If item 27 is marked other the nither traumatic event, the Med	٩	19a. Informant's Name/Relationship (Typ Deja Watkins/mo					r or Rural Route Num y Bowie,				
- 명등 등 등		20a. Method of Disposition  1 Burial 2 Cremation 3	1	20b. Place of Dispos crematory or ot	ition (Name of		Date		city or Town, State		
Baltimore, Demir. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:		Chesapea					ville, MD		
Balt permit. Depart Import		21. Signature of Funeral Service License	xocton				Briscoe-To ton RD Wal				
Physician		23a/Part I. Enter the disease, or complice failure. List only one cause on each							Approximate Interval Between Onset and		
Examiner	ı		udden Unexp		ath in	Infancy	(SUDI)		Death		
		Sequentially list conditions, b									
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated C	ue to (or as a consequer								
recuted nand - transit		d.	ue to (or as a consequer								
[5] B. B. G	Medical	■ UNPENDED	AMENDED 23a,p	t.II,27,2	8a-f,pe	r me,g9	34 12–17–	12 sm			
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth		tal death	3 Ectopic pr	regnancy	23d. Date of de Month	elivery Day Year		
that the death certificate by the attending detached for use as	Physician	1 Yes 2 ✓ No 9 Unknown	4 Pregnant at time 9 Unknown	- C - d Alba	her (Specify)			31.475			
O. E hat the code by the etached	by Ph	Part II. Other significant conditions	-		underlying caus	e given in Part I			ute to the cause of death?		
ls, P.C quires that en signed l		Complications of	Prematurit	У			1Yes		Probably 4 Unknown ere autopsy findings available		
of Vital Records, P.O. og Physician: The law requires that the this certificate has been signed by then this certificate has been signed by meral director, page 2 should be detach	Completed						autop	sy prid m <u>ed</u> ? dea	or to completion of cause of ath?		
Vital Rec ysician: The l his certificate l	a l	25. Was case referred to medical			26.Pla	ace of Death (C	1 Yes :	2 No 1	Yes 2 No		
Vita	70 B	1 Yes 2 No		2 ER/Outpatient			lursing Home 5		Other:		
on of anding Physich.  r: After the funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)  fd 9-26-12	28b. Time of 1		njury at Work? Yes 2 🗶 No	•	now injury occurred 11	•		
Division Lal or Attendi rs after death. al Director: //	ertification:	determined	Accident Investigation   Accident   Accident								
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. The The Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical Co	29a. Certifier (Check only one)  2 Medical Examiner: Certifying Physician	n: To the best of my kno on the basis of examinat and manner stated.	wledge, death occur	red at the time,		, and due to the caus	e(s) and manner a			
J. iv	Me	29b. Signature and title of certifier	D AA			nse number			(Month, Day, Year)		
		30. Name and address of person who co	moleted cause of death	(Item 23a)	0.0	C.M.E.		September 2	27, 2012		
		Patricia Aronica-Pollak MD.	Assistant Medic	cal Examiner	900 W. Bal	timore Stree	et, Baltimore, Mi	21223			
St Regis	ate	31. Date filed (Month Day Year) 2 20	32. Registrar's Si	gnature A. A.	we						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 22, 2012 Physician/ 9:07p.m.M <u> Carrie Elizabeth Welch</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death St. Mary's Hospital Leonardtown St. Mary's Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 212-66-4305 **Director** 1 M 2 F 91 08/05/1921 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director 1 Tes 2 No Maryland St. Mary's St. Inigoes 10f. Zip Code 9 10e, Street and Number 10g, Citizen of What Country? ms 23a or must be r Funeral 20684 United States 47921 Beachville Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dee Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Armed Forces 1 Yes 2 XNo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: Completed 3 ₩ Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 8 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Etta Della Mary Samuel Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29026 Autumnwood Drive, Mechanicsville,MD 20659 Sellers/Daughter Brenda W. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/27/2012 Ridge, Maryland Michael's Cem. 21. Signature of Fineral S. Francisco Edward N. Brinsfield, Jr.M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Ends to Cold

Due to (or as a consequence of): disease or condition resulting in death) 14 Medical 3 **Examiner** Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to as a consequence of) Exami End stage rend
Due to (or as a consequence of): Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ▼ No Day 4 Pregnant 9 Unknown Pregnant at time of death signed by the ard be detached f 1 ☐ Yes ∠ i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? severe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending injury 24 hours after death. Funeral Director: A) Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5(00 Point (4) Rme 20650 Gerry **2** 5 2012

State Registrar

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egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 2012 Charles Keith Williamson 7:47 atm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Elkton** Examiner 4c. County of Death 7 Circle Avenue cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Months Days Hours Min. 58 Director 325-60-4470 1 XM 2 F Syracuse, NY Aug. 13, 1954 or than "neturel", or itsms 23e or 28e-f show the Medical Exemples must be existed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with tha Meryland Director Ceci1 E1kton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funera 21921 7 Circle Avenue deeth \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces2

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ within 72 hours efter Maryland 21215-0036 white 1 Yes 2 X No Specify. Specify. Completed 3 Widowed 4 Divorced n res, Give Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) contractor construction 12 it. Pege 1 and 2 should be filed with them of Heelth and Mentel Hyglentent: If itsm 27 is marked other 1 njury or other trsumetic event, the njury or other trsumetic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ancilina Keith Robert Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Circle Avenue Elkton, MD 21921 Helen Williamson (wife) altimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Dapertment of I Importent: If Its sny injury or of once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Spring Grove Cem. Sept.22,2012 Cincinnati, Ohio 22. Name and Address of Facility
McCrery & Harra Funeral Homes & Crematory, Inc. 21. Signature of Funeral Service License M00 3924 Concord Pike Wilm., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponded to the death. Do not enter the mode of dying, such as cardiac or respiratory arresponded to the death. Do not enter the mode of dying, such as cardiac or respiratory arrespiratory arresponded to the death. Do not enter the mode of dying, such as cardiac or respiratory arrespiratory arresp Approximate Interval Between Onset and Death Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospitel or Attending Physicien: The lew requires that the death certificate be executed 24 hours efter death.

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Funsrel Director: After this certificate has been signed by the attending physicien and etely filled in by the funerel director, page 2 should be detached for use as the buriel-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No Completed Probably 4 🗆 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 9 No Other: 4 Nursing Home & P Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hou To the Funsi completely fi (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) Type, Print 31 Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistrarFCHD/amend #10e perFH/dc Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Conrad Barthel Weinrich September 14, 2012 12:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Glade Valley Nursing Home Walkersville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 292-30-5873 79 **Director** 1 🏝 M 2 🗆 F June 18, 1933 Michigan 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Walkersville Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a o 8531 Fortune Place Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 21793 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4 or 5+) Certified Public Accountant Accounting other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic even 2 Helen Barthel Carl Weinrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 290~Stafford~Lane,~Harpers~Ferry,~WV~25425Julie Cahall / Daughter item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept Date 20, 20c. Location - City or Town, State ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Department of Important: If i any injury or or Resthaven Crematory Frederick, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature uneral Serve License Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the diseas shock, or heart failure Immediate Cause (Final disease or Indition or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between The tructivo lung Discare Chronic Onset and Death Ph\_sician/ disease or moditi resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause injury Due to (or as a consequence or). g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery signed by the atter d be detached for I Live Birth 2 Fetal death 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Pregnant at time of death Month 1 Yes 2 9 Unknown Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ this certificate has been signal director, page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?

1 Yes 2 No death? or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 1 Tyes Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending injury Natural work 1 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be within 24 hours after death

To the Funeral Director: completely filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 2 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

FROMERUS MO 2/402

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3,2012 William Watson 12:05P M Ν. Sept Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Clinton 9303 Pella Place 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 578-16-1786 1**x** M 2 □ F Oct.18,1918 Wash., DC 93 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits Clinton PG 1 Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 20735 9303 Pella Place <u>United</u> States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 ☐ Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Dept. of Defense 11 Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ella Unk. John Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Shady Glen Drive District Heights, MD. 20747 Department of Health ar Important: If item 27 is any injury or other trauonce. Carolyn Culbreath/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/2<sup>Date</sup>/12 1

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, MD 21. Sonatule of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. Suitland, MD. 20746 3910 Silver Hill Rd., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ atheroscleroni Cardiovascular disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) -fran that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Be Completed by Physician/Medical Box 68760 the use as IF FEMALE: . If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ate has been signed by the atter page 2 should be detached for i in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_ Month Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \) Yes \( 2 \) 24a. Was an After this certificate has autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 No Other: 4 \(\sum\_\) Nursing Home 5 \(\overline{A}\) Residence 6 \(\sum\_\) Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural To the Hospital or Attending Physicial 24 hours after death.

To the Funeral Director After the completely fille in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) 025001 Sept 18,2012 35m Jay Lippman, MO
31. Date filed (Morlin, Day, Year)
SEP 2 0 2012

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WILLIAM JOHN WILLIAMS extember 15 2012 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death TIMON Sai If Under 1 Year If Under 24 Hrs. Social Security Number . 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 183-22-4927 Director 1 X M 2 □ F 84 06/19/1928 PENNSYLVANIA ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director QUEEN ANNE'S CHESTER 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4009 BRIDGEPOINTE DRIVE 21619 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within nent of Health and Mental Hyglene. ant: If item 27 is marked other tha 12 MASTER SERGEANT U.S. ARMY permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANDREW HUGO WILLIAMS HELEN ELIZABETH GERNHARDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4009 BRIDGEPOINTE DRIVE, CHESTER, MD 21619 WILLIAM A. WILLIAMS / SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
ARLINGTON NATIONAL
CEMETERY 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) UNKNOWN ARLINGTON, VA 21. Signature A Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Immediate Cause (Final Physician/ wee disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician for use as the burial Be Completed by Physician/Medical Box 687 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? i 24 hours after death. • Funeral Director: After this certificate has been signetely filled in by the funeral director, page 2 should t 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 2 No 1 Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 🗌 Yes 1 Dinpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Division of 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the basis of my knowledge, death consumed at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F 29b. Signature and title of certifu who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SEPT. COLBY 2012 JEANETTE WILSON-BERNS 3:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) Director 216-64-4278 1 □ M 2 🕅 F Yrs 58 OCT. 20, 1953 MARYLAND 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location the Maryland Director 1 ty Yes 2 ☐ No MONTGOMERY MD. SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 14027 CASTLE BLVD, #403 20904 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. چ 1 Never Married 2 X Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced Completed Year or Dates WHITE 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SERVICES MORTGAGE PROTECTION Elementary/Secondary (0-12) College (1-4 or 5+) INC. permit. Page 1 and 2 should be filed with Department of Health and Mental Hygient Important: if item 27 is marked other that any injury or other traumatic and page. SALES PERSON æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MASKE FREDERICK WILSON BETTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNS/HUSBAND 14027 CASTLE BLVD. #403, SILVER SPRING, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 9-18-2012 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, Cem CLEVELAND AVE. M00091 RIVERDALE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death 15 MONTHS Physician/ ENDOMETRIAL CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-<u>transit</u> transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown g | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Detrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54378 SEPT. 16, 2012 acuri 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) AYLESWORTH, CHERYL M.D. 2730 UNIVERSITY BLVD., WHEATON, MD. 31. Date filed (Month, Day, Year) State SEP 19 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 17, 2012 6:00 P M Steven Gary WEXLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Rockville Montgomery Hospice Casey House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth Hours (Month, Day, Year) 133-44-5512 1 M 2 D F **Director** 60 1951 New York Sept. 25. Usual Residence of Decede 28e-f show or than "natural", or items 23a or 28e-f sho the Medical Examiner", ust by will of all 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director N. Potomac 1 🗆 Yes 2 🔀 No Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20878 14305 Outpost Way be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 😾 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify If Yes, Give 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Department of Elementary/Secondary (0-12) College (1-4 or 5+) Veterans Affairs Biomedical Engineer treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental P ည Bernice Fisher Philip Wexler t. Page 1 and 2 should by thent of Health and Mer tent: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14305 Outpost Way, N. Potomac, MD 20878 19a. Informant's Name/Relationship (Type, Print) Ellyn S. Wexler, wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Judean Memorial Gardens 09/19/12 4 Donation 5 Other (Specify) Olney, MD 21. Signature of Funeral Sen Torchinsky Hebrew Funeral Home 20012 Carroll St NW. Washington. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Pancreatic Cancer Medical resulting in death) Due to (or as a consequence of) <sup>#</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician end letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease of Injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bigcirc$  Other (Specify) Hospice 은 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural work? 1 🗆 Yes 2 🗆 No 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier within 24 hou To the Fune completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 9.18.12 R 143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD

DHMH 17 Rev 06-2011

State Registrar

Debrah Miller, CRNP, 31. Date filed (Month, Day, Year) SEP 19 2012

32 Registrar's Signatu

20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Eugene L. Adams Sr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Regional Hospital Prince Laurel Laurel Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 579-34-0719 1 XXM 2 - F 83 May 10, 1929 Washington DC ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Hyattsville 1 K Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 Hill Road 20785 LISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 1 X Yes Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important; If item 27 is marked other the any injury or other them. Exhibits Specialist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eugene Adams Edna Louise Brisbon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10103 Prince Place #103, Upper Marlboro MD 20774 Glenda Adams (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Cheltenham Veterans Cem. 10/15/2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tristate Funeral Services, Inc. 814 Upshur Street NW, Washington DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Sepsis disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami Diabetes The law requires that the death certificate be executed vears -tran and that initiated events resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 g Unknown 2 No the a 9 Linknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Decubitus Ulcers, Hypertension, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy certificate 2 🗆 No Yes 2 No 1 TYPS To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D28998 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9101 Cherry Lane, Suite 211 Saini, MD State Registrar

DHMH 17 Rev 06-2011

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Imogene A1t October 4, 2012 Year 2:00 A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1306 Midvale Avenue Catonsville Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 19,1917 West Virginia **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 M 2 S F **Director** 215-24-5586 95 Usual Residence of Decedent 28a-f shov 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location Director Baltimore Catonsville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1306 Midvale Avenue 21228 27 is marked other than "natural", or items traumatic event, the Medical Examiner mus 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Secretary Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvin Vernon Shreve Cleda Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $102\ Forest\ Drive;\ Catonsville,\ MD\ 21228$ permit. Page 1 and 2 st Department of Health a Important: If item 27 is Polly Gardenghi Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Wilson Chapel Cemetery 10/9/2012 Upper Tract, West VA 21. Signature of Purperal Service Lice 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter 1 e disease, or comp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ gestive disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 4 ☐ Pregnant 9 ☐ Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, CAULEN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown perlipsulemii 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t 28d. Describe how injury occurred 1 Natural work? Pending ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Name and address of person who completed cause of death (Item 23a) (Type, Print) GeineRoad SSY, MartinMD

DHMH 17 Rev 7/2009

Registrar

OCT 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Matthew Jerone Adams Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Hours 214-50-2870 1 XM 2 D F Director Yrs. 64 10-17-1947 MD Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 522 South Beechfield Avenue 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 2 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Matthew J. Adams Marjorie Berryman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail J. Adams/Wife 522 S. Beechfield Ave., Balto. MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Date permit, Page 1 Department of Important: If it any injury or o 1 XBurjai 3 Removal from State 9-29-2012 Woodlawn, MD Other (Specify) 4 Donation 5 L 22. Name and Address of Facility Wille Fineral Hone P.A. of Balto. Go. 9200 Liberty Rd., Randallstown, MD 21133 art 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ heroso disease or condition resulting in death) Pours Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician Physician/Medical Hospital or Attending Physician: The lew requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy performed's death? 2 🗌 No 1 ☐ Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 뎯 2 🗓 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

United State of the Description of the Des 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 74267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 100th Day 2012 Physician/ 12:15 a<sup>M</sup> Charles Allen 2 Medical 4b. City, Town, or Location of Death Towson4a. Facility Name (if not institution, give street and number) Baltimore Examiner Gilchrist Hospice if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth **Funeral** (Month, Day, Y 9 / 4 / 4 9 Country) GA 63 062-42-0382 1 M 2 □ F Director end Mental Hygiene. 7 is marked other then "natural", or Itams 23s or 28s-f show raumatic evant, the Medical Examinar must be notified at 10c. City, Town or Location
Baltimorer 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director N/ABaltimore MD 1 X Yes 2 No 10f. Zip Code 21212 10e. Street and Numbe 10g. Citizen of What Country? 904 Woodson Rd Funeral USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. African Specify: Amor parmit. Page 1 and 2 should be fliad within 72 hours after or Dapartmant of Haalth end Mental Hygiene. Important: If Rem 27 la marked other than "natural", or any injury or other traumatic evant, the Medical Evandonce. 1 Never Married 2 Married Š ltimore, Maryland 21215-0036 1 Yes 2 No Specify: Amer. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Arts College (1-4 or 5+) Elementary/Secondary (0-12) Wood Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Allen ည John Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zig Code) 342 Millas RD, Statesville, NC 28625 342 Millas RD, Margarite Allen/Sister 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Bayview Crem. Balt.,MD 10/9/12 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. Close F. Sys, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Licens 23a. Part (. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter third or the Cause (Disease or injury that initiated events resulting in death) Last r as a consequence of) Examine ettending physicien and if for use es the burlai-transit Hospital or Attanding Physician: The lew requires thet the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death After this certificete hes been signad by the e funeral director, page 2 should ba deteched i 9 Unknown ditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant co 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attandin within 24 hours efter death.

To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No Investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide City or Town, State) Medical critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cereining Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of cert 29d. Date signed (Month, Day, Year) D0071282 hailes Ct. # 4105, Baltimore, MD 21204 MIOF

DHMH 17 Rev 06-2011

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		J	State of Maryland				lental Hy	giene		00001
		_]	State Registrar	Cen	tificate of D	eath		Reg. No. 2	112	32204
	Physicia Medic	n/	1. Decedent's Name (First, Middle, Last)  Margaret Clara Alter				2. Date of De Month October	Day	2 <sup>Year</sup>	3. Time of Death 9:00 A. M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or I			4c. County	of Death	
أمي		4	100 Marshall Drive	16:46 6 1	Forest I	Hill If Under 24 Hrs.	8. Date of Bir	Harf		lace (State or Foreign
	Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last</i> 1 □ M 2 🔀 7		Months Days	Hours Min.	(Month, Da	y, Year)	Count	ry)
1			Usual Residence of Decedent 92	Yrs.			Mar. 20	), 1920		
	land f sho	ţ	10a. State 10b. County 10c. City,	Town or Loc	ation				10	0d, Inside City Limits 1 ☐ Yes 2 🛂 No
	28a-	jred	CA Orange Tust	tin	10f. Zip Code		_	10g. Citizen of	Mhat Cours	
	ith the	ral	10e. Street and Number  100 Marshall Drive		21050			USA	What Oodii	uy.
	ath w	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His	spanic Origin? (Spe	ecify Yes or No-	14. Rac	e - America	
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003	urs af tural" al Exa		3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates.							ite
15-	72 ho n "nal fedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give F	ent's Usual Occupa aind of work done do ONOT use retired)	uring most of work	ing	16b. Kind of B	usiness/inc	dustry
212	within giene. er tha the N		Elementary/Secondary (0-12) College (1-4 or 5+)	Homen	naker			Own H	ome	
pu	filed all Hyg		17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surnam	e)	
yla	Ment Ment narke	은	John Joseph Reusing			Anna Mai			7:- 7:- C	Name to the state of the state
Mar	2 shot th and t7 is n		19a. Informant's Name/Relationship (Type, Print)  Bob Alter / Son		<sub>ig</sub> Address <i>(Street a</i> <b>Marshall</b> 1					
re,	Heali Heali Hem 2		20a. Method of Disposition 20b. Pla	ace of Dispo	sition (Name of		Date	20c. Location		
mo	ent o				natory or other place L SVCS , LI		-2012	Bel Air	, Mar	yland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signatur / nera/ ervice lacen e	22	. Name and Addres	s of Facility Mc	Comas F			
<u>m</u>	8 2 E 8 9		I would want	13	317 Cokes	bury Road	d, Abin	gdon, Ma	rylar	
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one caute on each line.	. Do not ente	or the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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		iner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of the conditions).	ence of):						
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	ate be executed physician and the burial-transit	al E	resulting in death) Last Due to (or as a conseque	ence oi).						
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68	eath certificate attending phy d for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal	ncy Ideath 3.5	Ectopic pregnanc	:V			ate of deliv	
Box 687	death	Physician/Me	in the past 12 months?  1   Yes 2   No 9   Unknown		Other (specify)			M	onth	Day Year
P.O.	hat the dea led by the a detached f		Part II. Other significant conditions contributing to death but not resu	ulting in the u	underlying cause glv	en in Part I.	23e. Did	tobacco use con	tribute to th	ne cause of death?
S, P.	requires that been signed k should be det	d by					1 🗆	Yes 2 No	3 🗌 Pro	bably 42 Unknown
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alF	ertifica ector, p	Be C	25. Was case referred to medical examiner?			ace of Death (Chec			-	
of Vital	Physiciar r this certif eral directo	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatie 28b. Time o		4 ☐ Nursing H		how injury occur		<u>) Son's</u> esidence
n o	ding F h. After funer	cate	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	work	Yes 2 No	Zod. Describe	now injury occur	Ri	esidence
Division	Atten er deal ector: by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined building, etc. (Specify)	me, farm, sti	reet, factory, office			(Street and Numi	ber or Rura	l Route Number,
Div	tal or rs afte al Din led in	S C	building, etc. (Specify)							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowle 2 Medical Examiner. On the basis of examination 3 Certifying Nurse Practitioner: To the best of m	and/or inves	stigation in my opinio	on, death occurred	at the time, date	and place, and d	ue to tne ca	iuse(s) and manner stated
	To the within To the compli	Σ	only one) 3 LI Certifying Nurse Practitioner: To the best of m 29b. Signature and title of certifier	.,omouge	29c. License	e number		29d. Date sign	ed (Month,	Day, Year)
			Chalfor Ma			3588	/	Octobe	8	20/2
	1		30. Name and address of person who completed cause of death (Item  Charles)  31. Date filed (Month, Day, Year)  OCT 0 9 2012  32. Registrar's Signate Completed Cause of Death (Item)  33. Date filed (Month, Day, Year)	23a) (Type,	Print) MACPLA	il Re	1 Acad	MA	21	014
	Sta		31. Date filed (Month, Day, Year)  OCT 0 9 2012	ture Land	Kel	<del></del>				
	Regist	ar	■ UUI U 7 ZVIZ /22/29/20 /V·	17						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 01eksandr Anshukov 9:50 A October 5 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris 9. Birthplace (State or Foreign Country) Russia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 10/27/1929 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 218-55-2331 Director 1 🕱 M 2 🗆 F 82 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Pikesville Mary land Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21208 # 305 1450 Bedford Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 💢 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 9:50 Elementary/Secondary (0-12) College (1-4 or 5+) Construction Machinery Operator Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Anshukov Ivan Anshukov 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Phoenix, Maryland 21131 Glen Alpine Road Svetlana Lien / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State OCTOBER 4 ☐ Donation 5 ☐ Other (Specify) 10/11/2012 Towson, Maryland Hillton Service Corp. 21. Signature of uneral Service 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death OLEKSANDR ANSHUKOV 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To Be ( 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) HOSPICE 1 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred To the Hosping, ... within 24 hours after death.
To the Funeral Director: After a funeral precion of the funeral p Natural 5 Pending 1 ☐ Yes 2 ☐ No м Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check The basis of examination and of investigation, in my spinion, determined the cause (s) and manner as stated.

Kertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 **CRNP** 2300 DULANEY VALLEY RD. TRACIE L. MORGAN,

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

9

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Las 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air 706 Beretta Way If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Months Davs Hours Min. Director 1 🔀 M 2 🗆 F 233-34-6019 89 Vrs 1923 Apr.18 West Virginia If item 27 is marked other then "neture!", or items 23e or 28e-f show or other treumetic event, it a Medical Examiner must be included at Page 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Heelth and Mental Hygiene. ent: If item 27 is marked other then "neture!", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location Director 1 Nes 2 No Harford Bel Air Maryland 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21015 706 Beretta Way 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Y Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Automobile Elementary/Secondary (0-12) College (1-4 or 5+) Repairman Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stella (unk) Alt Frank James Alt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Beretta Way, Bel Air, Maryland 21015 Ruth Alt/ Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 of Popertment of Himportent: If ite eny Injury or ot 1 Burial 2 Cremation 3 Removal from State Bel Air Mem. Gardens Oct.9, 2012 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee McComas Funeral Home, P.A. 22. Name and Address of Facility Pessea wwwer 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of Exami Hospital or Attending Physicien: The law requires thet the death certificate be executed After this certificate hes been signed by the ettending physiclan and funeral director, page 2 should be detached for use es the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to edical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours efter death. To the Funerel Director: Aft completely filled in by the fur 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (T 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DIN Ann K 03:11 AM October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** laryland General Hospita Baltimore Ci If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours **Director** 20 1964 10b. County City, Town or Location 10d. Inside City Limits 10a, State 10c. notified at Director timore 1 Yes 2 No 28a-f 10g. Citizen of What Country? items 23a or ner must be n Funeral 21216 LISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc 9 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO HOT use retired) 15. Decedent's Education (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than traumatic event, the Me ondary (0-12) College (1-4 or 5+) orist Be Middle, Last) 2 ìle: Vlother 128 Health a artme t of Health ortant: If item 27 injury or other t d of Disposition **Y**Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License permit. I Der artm Im orts any inju 23a. Part 1. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ash Imonar Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Other (specify) Pregnant at time of death ☐ Pregnant a the a been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death. Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completely filled i Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO: MPH Octuber 06,2012 DOO 62183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 Linden Avenue Emergency Department Margarita BJOVEL MD MPH Baltimore, MD 21201

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM# 20a-c, per FH, G932, 10711, 2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month of 327 PM 1,00 2012 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death Randa ilstown PITO more If Under 24 Hrs. Age (In yrs. last birthday) lf Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Country) MD 1 □ M 2 🗹 Days Hours Min. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County City, Town or Location 10d. Inside City Limits Director timore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 151 21201 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Armed Forces? Black, White, etc. 1 Newer Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes, Give Blac 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) lurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ara no MD 21229 Baltimore, 20a. Method of Disposition Location - City or Town, State Hanover 20b. Place of Disposition (Name of Date Burial 2 🗷 Cremation 3 🗌 Removal from State Cremation or other placed er -10-2012 4 ☐ Donation 5 ☐ Other (Specify) 19/Vimore 22. Name and Address of Facility Vaus ha 21. Signature of Funeral Service License 8 au 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examin sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 months? Dav Year Pregnant at time of death 3 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2-No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Tes Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury М 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) DOUGLETU actober 03 2012 son who completed cause of death (Item 23a) (Type, Print) Court road icindalistown MD 2/133 5401 (7wibi 32. Registrar's State QCT 0 9 Registrar

Please Type or Print in Black indelible ink. Ensure All Copies Are Legible.		
State of Maryland / Department of Health and Mental Hygiene	2012	32201
Certificate of Death Reg. No.	2012	3660

		1- For State Registrar	C	ertificat	e of Dea	ith		R	eg. No.	12 3220
Physici		Decedent's Name (First, Middle,Last)		- Lu				2. Date of Dea	th Day Year	3. Time of Death
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Funeral		5. Social Security Number 6. S		s. last birthd			nder 24Hr	s. 8. Date of Bir	th(MM/DD/YYYY) g.	Birthplace (State or
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		216-17-0195 12 Usual Residence of Decedent	ØM 2□F	82	Yrs.			02/20	-119/9	Country) PtD
any		10a. State 10b. County	10c. C	ity, Town or	Location					10d. Inside City Limits
<b>A</b> .	_	MD	1	30-16	esda					1 Yes 2 No
daryland <b>28a-f show</b> 1 at once.	cto	10e, Street and Number		10,11		ip Code		1	0g. Citizen of What 0	Country?
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland tend 77 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	<u> </u>	11. Marital Status	12. Was Decedent Ever in			dent of Hispanic (	Origin? ( S	specify Yes or No	- 14. Race - Ar	merican Indian, Black,
r iten	Funeral	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No		If Yes, spec	city Cuban, Mexic	an, Puerto	o Rican, etc.)	White, etc	c.
after o	by F	3 Widowed 4 Divorced	If Yes, Give Year		1 Yes	2 No spec	ify:		Specify: 13	LACK
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin		15. Decedent's Education (Specify o	nly highest grade completed)			I Occupation (Gi orking life, DO N			16b. Kind of Busine	ss/Industry
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5-0036 lled within 7 Hygiene. I other than	ЩČ	12	4	EN	MREP	RENEU	K		SP OR Maiden Surname)	15
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2121 Muld be fill Mental E marked	o Be	Yaw Badu 19a, Informant's Name/Relationship (1	Type Print )	10h M	Anilina Addres	H H	1a	Kumi	ber, City or Town, S	tota Zin Cada
MD 2121 d 2 should be fi lth and Mental I n 27 is marked numatic event,	ပ	0 1 0 1	Brother							
e, MC 1 and 2 sl Health ar item 27	1	20a. Method of Disposition		o. Place of D	isposition (Na	ame of cemetery,	<del>- ' ·</del>	Date	20c. Location - City	VI 48185 v or Town, State
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Balti permit. Departm Imports		1 Meurial 2 Cremation 3 4 Donation 5 Other Specify 21. Signatur of Funer Screen Licer  23a. Part I. Enter the disease, or comparity on cause on comparity on cause on comparity or comparity on comparity or comparit	101557	- 1	Hans	Vock	P	TUGHN	THEOLE	Md. 2012
Physician		23a. Part I. Enter the disease, or comp	plications that caused the dea	ith. Do not e	nter the mode	of dying, such a	s cardiac	or respiratory arre	est, shock, or heart	Approximate Interval
/Medical		randle. List offiny offe cause off ea	ach line. Multiple Injuries							Between Onset and Death
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	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	of):						
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7 <b>60,</b> ficate be ext g physician the burial -	ΣΙ	IF FEMALE:	23c. If yes, outcome of pro						23d. Date of deliv	very
68 Sertifi ading	ä	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of	1	_	3 Ecto	pic pregna	ancy	Month	Day Year
Box 68° e death certificate attending ed for use as	Physiciar	1 Yes 2 No 9 Unknown		death 5	Other (Spe	ecify)			1	
D. B. It the de ached f		Part II. Other significant conditions	contributing to death but no	t resulting in	the underlyin	g cause given in	Part I.	23e. Did to	bacco use contribute	to the cause of death?
cords, P.O. aw requires that the ras been signed by 2 should be detach	ğ							1 Yes	2 ✓ No 3 ☐ P	Probably 4 Unknown
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e law e has ge 2 sh	Ē							autops	med? death	
	ပ္ပ	25. Was case referred to medical				26. Place of Dea	th (Chack	1 Yes 2	2 No 1 ✓	Yes 2 No
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of of the the neral of	은	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		e of Injury	28c. Injury at We		28d. Describe h	ow injury occurred	
endin ath.	힐	1 Natural 5 Pending	Sep 27, 2012	1000 hi	rs	1 Yes 2	<b>✓</b> No	Subject jump	oed of major roa	id overpass
Division tal or Attendi rs after death. al Director: A	[월	2	28e Place of Injury - At	home, farm,	street, factor	y, office building,	etc.			Rural Route Number, City
Distriction of the control of the co	Certification:	4 Homicide determine		ad Overp	ass			or Town, St S/B I-95 ramp	ate) of W/B 695, Esse:	x, MD
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifit completely filled in by the funeral director.			an: To the best of my knowle							
o the vithin o the omple	Medical	one) 2 Medical Examiner	On the basis of examination and manner stated.	and/or inve	stigation, in m	y opinion, death	occurred a	at the time, date a	and place, and due to	the cause(s)
F > F 3	ž	29b. Signature and title of certifier			29	lc. License numb	er		29d. Date signed ()	Month, Day, Year)
		and has				O.C.M.E.			September 28,	, 2012
31	Ì	30. Name and address of person who								
JY			edical Examiner 900			et, Baltimore	, MD 21	1223		
St Regist	ate	31. Date filed (Month, Day Year)	32. Registrar's Signa	dure K	/					
Kegis	15:11	44. 44. 44								

		amend #5	Per FH C932 1	0/09/201 0/ Departi	allole Ink. Ensure 2 JH nent of Health and FH, G932, 10/15/2 cate of Death	Mental Hy	giene	gibie.	
	_	State     Registrar  1. Decedent's Name (First, Middle, Last		Certifi	cate of Death	1	5	012	32210
Physicia Medi	cal	EllEN BOY	1			2. Date of Dea Month OCTOBER	3 2	o IZ	3. Time of Death 12:13 M
Exami	ner	4a. Facility Name (if not institution, give s	Court	46	Dwines Mil	1/5	4 <del>c. S</del> ound	y of Death	nore
Funeral Director		5. Social Security Nymbol, 6. Se		st birthday) If Mo	Under 1 Year If Under 24 Hrs onths Days Hours Min.		192/1		olace (State or Foreign
and show	'n	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Locatio	n			1	0d. Inside City Limits
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with the 23a or 1st be r	Funeral Director	10e. Street and Number	Court		0f. Zip Code 2/1/7		10g. Citizen of	What Cour	try?
death ritems iner m		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces? 1  Yes 2 No	13. Was	Decedent of Hispanic Origin? (S , specify Cuban Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - Americ	
filed within 72 hours after death with the Maryland all Hyglene at the "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	ed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1	1 🗆	Yes 2 No Specify:		Specif		cK
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should e filed within and Mental Hygiene is man ed other the aumati event, the	To B	17, Father's Name (First, Middle, Last)  Walter M.	Ballard	•	Ellen	me (First, Middle,	5		
42 th 22 th		19a, Informant's Name/Relationship (Ty)	1/	19b. Mailing Ad	ndle Dendance	Blvd. /	r, City or Town,	State, Zip C	ode) 19720
ge 1 and nt of Heal : If item		20a. Method of Disposition  1  Burial 2  Cremation 3	20b. P	lace of Disposition emetery, cremator	n (Name of ry or other place)	Date <b>VA-K</b>	20c. Location	-	wn, State
permit, Page 1 Department of Important: If i any injury or once.		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service License	, , , , , , ,	rema til 22. Na		26-2012	Hano Funeral	ver .	MICP (
Depariment of the policy of th		Vaugha C.	Diene	187	28 Liberty 1	El Ran	ola 1/5 t	DWNN	1021133
Physician/		23a. Part 1. Enter the disease, or com- shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		e mode of dying, such as cardiad	respiratory arr	est,		Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	ence of):	î.				
	iner	Sequentially list conditions,	b. Due to (or as a consequ	FALLUR ence off.	E				
be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Typenum	1. LEMI	A				
te be ex nysician ne burial	cal		d. Hypenten	s, ON					
certifica nding pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If <u>ye</u> s, outcome of <u>pr</u> egnal	ncy			23d. D	ate of delive	erv
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		topic pregnancy her (specify)		- 1	lonth	Day Year
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w requires s been significations in the standard of the standa	Completed					24a. Was	an 24b	. Were autor	psy findings available
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Ing Phy Ing Phy After thi		27. Manner of Death  1 X Natural 5 Pending		28b. Time of injury	28c. Injury at work?	28d. Describe h			
r Attendir er death. rector: Af by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)	me, farm, street, t	M 1 ☐ Yes 2 ☐ No actory, office	28f. Location (S City or Tow		ber or Rural	Route Number,
spital or ours aff leral Di		29a. Certifier 1 Certifying Phys			red at the time, date and place,			ner as state	d.
the Hos nin 24 h Ithe Fun npleted	Medical	(Check 2 Medical Examin	er: On the basis of examination	and/or investigati	on, in my opinion, death occurred	at the time, date a	nd place, and d	ue to the car	use(s) and manner stated.
Voint Coun		29b. Signature and time of certifier	wells		29c. License number		29d. Date sign	ed (Month, l	2012
21		29b. Signature and title of certifier  29b. Name and address of person who compared to the co	ompleted cause of death (Item	23a) (Type, Print)	11 0110 12	ECSEV	111) 2	127	1
Sta	te_	MANUE   EVEZ- 31. Date filed (Month, Day, Year)	32. Registrar's Signat	4 EASTE	ENN BLUD E	->-E X /	VI C	,	
Registr	ar	UCT 0 9 2012	Denve S.	barket					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year October 5 Marcia Clark Barr 7:20 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 222 Beechview Court <u>Baltimore</u> Towson . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) Director 280-42-4570 1 M 2 X F 65 Dec. 5, 1946 Ohio Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho 10a, State 10b. County irector 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Baltimore Towson ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 222 Beechview Court 21286 death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) le 1 and 2 should be filed within 72 t of Health and Mental Hygiene. If item 27 is marked other than "yed or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Commercial Real Estate Agent Own Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any Injury or other traumatic « Richard Clark Evelyn Stark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Courtney Barr/ daughter 7036 Strathmore Street Apt#311 Chevy Chase,MD.21815 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/6/2012 Baltimore, Maryland Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc 21. Signature of Fun 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Yancreas Canul disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and I for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or i Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death been signed by the s should be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an s certificate has build director, page 2 s autopsy Yes 2 N 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, of Vital æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes 2 Mo 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending injury Division 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hor. To the Funer completely fi Medical Examiner: On the basi, of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitionar to the best of my knowledge, death occurred at the time. Jate and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D67143 2012 05 30. Name and address of who completed cause of death (Item 23a) (Type, Print) Baltimore Ollrans St 31. Date filed (Month, Day, 32. R State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Ma	rvland	d / Depa	rtmen	of He	ealth a	and Me	ental Hv	giene	,		
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* *	Dhusisi	7	1. Decedent's Name (First, Middle, Last,							:	2. Date of De. Month	ath Day	Year	3. Time of Death	
	Physicia /Medic		Thomas G. Ba								octobe	5	2018		м
<b>)</b>	Examin	er	4a. Facility Name (If not institution, give				4b. City,	11.	Location o	_		4c. Cou	nty of Deat	n	
	Funeral	.X.	Med Star Good 5  5. Social Security Number 6. Sec		(In yrs. la	ast birthday)	If Under	1 Year	If Under	24 Hrs. (	8. Date of Birt	th	9. Birt	hplace (State or Foreig	gn
	Director		218-80-8417	<sup>M 2□F</sup> 53		Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da 01/24/	1959		MD MD	
and	3		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limit	ts
Mary	-f sho	tor	MD Carroll		Fir	ıksbu	rq							1 ☐ Yes 2 ☑ 1	6
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ath wi	23a c	Funeral Director	1825 Fawn Way					1048				Unite			
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lial) 2 sho	is me	ľ	19a. Informant's Name/Relationship (T)	rpe, Print)			•					er, City or Tov		Zip Code)	
1 and	Health em 27 ther t		Steven Barron-s  20a. Method of Disposition	on	20b. PI	1825 ace of Dispo					ourg, f	4D 21 ( 20c. Locatio		Town, State	
nor ages	ant of it: If it y or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)			ametery, cren uth C				10/9	9/12		field		
Dailling	Department of Health and Mental Hygiene. Important; or Itema 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at one.		21. Signature of Funeral Service Licens	- 21	711	_ 22					l	Funer	cal 8	Cremati	on
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tificate	ig phy as the			u											
th cer	tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2			Ectopic pr	egnancy				23d.	Date of del	livery Day Year	
ords, F.O. DOX of requires that the death certifica	the a	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at t 9□ Unknown	time of de	eath 5	Other (sp	ecify)							
that .	ned by detar		Part II. Other significant conditions co	ntnbuting to death bu	t not resu	ılting in the u	nderlying c	ause give	n in Part I	,	23e. Did 1	obacco use c	ontribute to	the cause of death?	
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e g	erthis neraldi	-	27. Mannec of Death	28a. Date of Injury (Month, Day	y	28b. Time o		8c. Injury Work	at			how injury oc		спу)	
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JIVIS or Att	iter de Direct in by t	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc			reet, factor	y, office		2		Street and Nu wn, State)	imber or Ri	ural Route Number,	
pite.	ours a	O	29a. Certifier 1 Certifying Phy	ysician: To the best o	f my kno	wledge, deat	h occurred	at the tim	ne, date an	nd place, a	nd due to the	cause(s) and	manner a	s stated.	
e Ho	n 24 h ne Fur oletely	Medical	(Check only 2 Medical Exam one)	iner: On the basis of and manner stat	examinat	tion and/or in	vestigation	, in my op	oinion, dea	ith occurre	ed at the time,	date and pla	ce, and due	e to the cause(s)	
Tot	within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Σ	29b. Signature and title of certifier	Baker	170	)		. License	· · · · · · · · · · · · · · · · · · ·	מ ר		29d. Date sig	ned (Mont	th, Day, Year) 05 20/3	,
	/ Non							/	857					J J J T C	_
	3		30. Name and address of person who co	Sa Kin /7.		560/	Coc	41	avea	101.	ud 1	Balten	ore		
	Sta		31. Date filed (Month, Day, Year) OCT 0 9 2012	32. Registra	r's S	Me							-		
	Registi	rar	ULI U 9 ZUIZ /CA		• #										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BAJANA Day 28 2012 Physician/ DIDNISID SENT 01:15 KM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, 4c. County of Death 430 MAUR COUMBI HOWARD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Director 229-25-0701 1 x M 2 - F February 15,1955 **Philippines** 57 Usual Residence of Decede 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f sho **Funeral Director** 1 Yes 2 X No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5907 Tamar Drive 21045 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 K Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Asian 3 Divorced 4 Divorced th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) Driver Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Marcelina Ros Ramon Bajana 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5907 Tamar Drive Columbia, Maryland 21045 Adelina Bajana (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Michael's Church Cem. 10-27-2012 Mahinog, Camiguin 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. Columbia, Maryland 21045 5555 Twin Knolls Road Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760 Division of Vital Records,

State

Registrar

who completed cause of death (Item 23a) (Type, Print)

2 | 3 |

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Co dar-Laus

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend
item II per inf g934 12-14-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Month Year 8:15 PM September 30 2012 Carolyn Theresa Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Dulaney Baltimore Towson 8. Date of Birth (Month, Day, Year) Nov 26, 1945 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 66 **Director** 129-34-1687 1 🗆 M 2 😿 F Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 United States 305 E. Joppa Rd. 503 Apt. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 200 Completed by 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) United States Postal Elementary/Secondary (0-12) College (1-4 or 5+) 12 Postal Clerk Service traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leonard Brown Ruby Brown I and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo-Ann Dotson /Cousin 3525 Alameda Cir. Baltimore, MD 21218 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State . Page 1 Oct 06 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 permit. 22. Name and Address of Facility Signature of Funeral Service Licensee Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21296 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph si ian/ disease or condition Medical resulting in death) Un Known. **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or a a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence resulting in death) Last Division of Vital Records, P.O. Box 68760  $\mathscr{L}$ 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 WN Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: filled in by the funeral director, Be examiner? Hospital: Other: 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) s after death. 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work?
1 Yes 2 No 5 Pending М Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours af thin 24 hours af Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0-12849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER Dr. TONSON 600 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9.08 AM BROWN Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthda) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 1 □ M 2X□ F 86 215-26-1117 MD July 28 1926 of Health end Mental Hygiene. I feem 27 is marked other than "netural", or items 23e or 28a-f show other traumatic event, I're Modical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Marriottsville 1 ☐ Yes 2 🔀 No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21104 within 72 hours after death with 1090 Henryton Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give black Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Howard Co. Schools custodian 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and 2 should be Department of Health and Menta Importent: If tem 27 is marked eny injury or other traumations ഉ Edith Thomas Costley Amos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1090 Henryton Rd., Marriottsville, MD 21104 Mr. Wayne Brown Sr. (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Liberty UMC Cem 10-9-12 Marriottsville, MD 21. Signature of Funeral Service License 22. Name and Address of FacilityHaight Funeral Home & Chapel Parguspargnt Serbert Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between t and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying burial-transit To the Hospitallor Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Unector After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 D NO ၉ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Limitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ature and title of certifier 29b. Sign ho completed cause of death (Item 23a) (Type, Prin 30. Name

State

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 20 I 2 BERGER 10:10 Ρм THOMPSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S MANOR CARE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 😿 M 2 □ F Months Days Hours Min OCT. 26, VIRGINIA 99 1912 Director 237-05-7554 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND CHARLES WHITE PLAINS 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a or Examiner must be Funeral UNITED STATES 10318 HOUSELY PLACE 20695 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. nan "natural", Medical Exar Specify: BLACK 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 72 1 (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the PRIVATE MINISTER 8TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be file aith and Mental I 27 is marked on traumatic eve ၉ HAZARD TURNER JOE BERGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traunonce. 10318 HOUSELY PLACE, WHITE PLAINS, MARYLAND 20695 RUBY CLARK-WILSON / NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State LAWN CEMETERY 10/12/2012 SHARON HILL, DELAWARE Donation 5 Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final Physician/ UNGESTIVE disease or condition resulting in death) Medical **Examiner** CARDIOMYOPATHY MUNTITY EVERE ISLITEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-/Medical the attending plant the strength of the streng IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown g 🗌 Unknown ed by t signed by be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed certificate has page Be မ Certificate:

Division of Vital Records, P.O. Box 68760 Hospital or Attending death. Director: / after n 24 hours a

				1 Yes 2 🖟 6 3 Probably 4 Unknown						
				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No						
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1  Yes 2 No	Hospital: 1									
27. Manner of Death  1 Matural 5 Pending 2 Accident Investigatio		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be determined	1 290 Diago of Injuny . At h		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
00- 0-45 4 Do-45 Db	alalan Table back of an Inch									

29b. Signature and title of certifier

(Check

only one)

D0051437

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMNAPULIS RD STE 232 GLENN DALE IBITOYE 200 31. Date filed (Month, Day, Year

State Registrar

filled in by

OCT 09

ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show and other than "	/ Il r	Decedent's Name (First, Middle, Lasi     NICHOLAS     A. Facility Name (if not institution, give						Reg. No		-	
Funeral Director	5	la. Facility Name (if not institution, give:	BARNES				2. Date of D Month OCTOB	Da	201	ar 2	3. Time of Dea
3		BOWIE HEALTH CE	ENTER  7. Age (In yrs. Ia		4b. City, Town, o  BOWIE  If Under 1 Year  Months Days	If Under 24 Hrs Hours Min.	8. Date of B	irth	PRINCE	GE(	ace (State or Fo
with the Ma 23a or 28 ust be noti		217-11-5948  Usual Residence of Decedent  10a. State  10b. County	10c. City	Yrs.	cation		APRIL	10	1985		HINGTON .
3 2 3		MD   PRINCE GR 10e. Street and Number 904 JAMES VIEW LA		WIE	10f. Zip Code 20721			10g. Ci	itizen of Wha	t Count	
s after death ral", or items Examiner m	2	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates.		Was Decedent of H f Yes, specify Cuba		pecify Yes or No o Rican, etc.)		14. Race - A Black, V Specify:		tc.
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t should be filed v h and Mental Hyg 7 is marked othe raumatic event,		17. Father's Name (First, Middle, Last)  NATHAN BARNES				18. Mother's Na		e, Maiden	Surname)		
1 and 2 shou of Health and item 27 is rr other traum		19a. Informant's Name/Relationship (Ty) DONNA BARNES/MO	THER	904	JAMES VI		BOWIE, N	1ARYI	LAND :	2072	21
permit. Page 1 a Department of I Important: If ite any injury or ot once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State Co	emetery, crer ARMONY	sition (Name of natory or other place CEMETER)	Y 10-	Date 12-2012	LAN	ocation - Cit	, MAF	YLAND
permit Depar Impor any in		21. Signature of Funeral Service Licens	"Cornelius	7	Name and Addre						-
Physician/ Medical		23a. Part 1. Enter the disease for comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a. Osteosarcoma		er the mode of dyin	ig, such as cardiad	or respiratory a	arrest,			Approximate Interval Betwee Onset and Deat Years
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e be executed ysician and e burial-transit		Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequent d.	ence of):							
To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death certificate has been signed by the attending physician for the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burnander of the funeral filled in filled in the funeral filled in the	lysiciali/ivied	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnand Other (specify)	су			23d. Date o Month		y Day Year
requires that the been signed by should be deta	leten by FI	Part II. Other significant conditions	ontributing to death but not resu	ulting in the u	inderlying cause gi	ven in Part I.		Yes 2	X No 3	Prob	e cause of death
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Physician: r this certificated director		evaminer?	Hospital:  1  Inpatient 2	ER/Outpatier	nt 3 🗆 DOA Oth	4 ☐ Nursing I	dome 5 Res		6 Other (S	te H	ealth (
or Attending P after death.  Director: After t in by the funera	IIICar	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury me, farm, str	M 1 🗆					r Rural I	Route Number,
spital or A lours after veral Dire filled in b		4 ☐ Homicide determined  29a. Certifier 1 ▼ Certifying Phys	building, etc. (Specify)	edge, death	occured at the time	e, date and place.	City or To	wn, State	nd manner a	s stated	
the Hospital ithin 24 hours of the Funeral ompleted filled		(Check 2 ☐ Medical Examination only one) 3 ☐ Certifying Nurse 29b. Signature and title of certifier	ner: On the basis of examination e Practioner: To the best of my	and/or inves knowledge, o	tigation, in my opini death occurred at the 29c. Licens	e time, date and pl	at the time, date ace, and due to t	the cause(	e, and due to (s) and manne ate signed (M	r as sta	ted.
E S E ŏ		30. Name and address of person who c	ompleted cause of death (Item	23a) /Time 5	D527				10/8/		
State			800 Orleans St	treet,	Baltimo	re, Mary	land 212	287			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 1 Day 2012 Year 10:27 AMM Lois E. Brunkhorst Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 150-26-6412 1 □ M 2**X** F 77 Oct 14, 1934 New Jersey or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 122 Branch Street USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: white 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 registered nurse healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Frederick Aaron Brunkhorst Martha Arlene Kenyon permit. Page 1 and 2 st.
Department of Health an Important; If item 27 is m any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Atlantic General Hospital 9733 Healthway Drive Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🗋 Cremation 3 🔲 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signa up of Funer Service Licenses 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Wade Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ obstroch've Pulmohom disease or condition resulting in death) Chachic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause (Disease or injury Due to for as a consequence of, physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 🗌 Yes မ 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending М Investigation Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completely filled runkhorist 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number D0064120 0//2012 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Health Way Drive Berlin M'D Zeeshan AUH 31. Date filed (Month, Day, Year) State OCT 0 9 2012 Registrar

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10/01/2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Bowie 15508 Norwegian Court 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days Hours Min. (Month, Day, Year) Director 220-34-5195 73 Oct 6, 1938 Maryland 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Prince George's Bowie 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 15508 Norwegian Court 20716 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 3 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates white Completed 3 Widowed 4 Divorced unk 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be filed nt of Health and Mental Hi t: If item 27 is marked otl James Pickens Grant Berenice Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson Bock/spouse 15508 Norwegian Court Bowie, MD 20716 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sine tue of Funeral Service Licensee 22 Name and Address of Facility State Anatomy Board Baltimore, MD 2120 655 W. Baltimore Street Director Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) Nursing Home \( 5 \overline{\text{Residence}} \) Residence \( 6 \overline{\text{Nother}} \) Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1-Natural 5 - Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) ure and title of certifier oper012012 Name and address of person who com of g ath (Item 23a) (Type, Print) 10 HAER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / O Physician/ BYRON Day 2 Zolz J. BADEN 08:44 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNIV. MARYLAND MEDICAL CENTER NOT APPLICABLE If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year 215.28.1412 Director 1**XX**M 2 🗆 F 82 Sept 17, 1930 Usual Residence of Decede 28a-f show with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits must be notified 1 Yes 2 No MD Anne Arundel Severn 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 48 Cambrills RD permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. 2 No. 1951 -Black, White, etc. 1 Never Married 2 Married Completed by XXYes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XX Specify. 3 Widowed 4 Divorced Year or Dates. 1954 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Automotive Master Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Edwin Baden **Eunice Pratt** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Gambrills Rd., Severn, MD 21144 Nancy Krebs Baden 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Oct 5, 2012 Baltimore, MD 21. Signature Funeral Service Legice

K. Gregory Fink M01148

23a. Part 1. Enter the disease or complications that caused a shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death ENDOCARDITIS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SEPTIC EMBOL Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of certificate be executed as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, lymphoblastic leukemia 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▶ No 24a. Was an has autopsy performed? Yes 2 No I or Attending Physician: The after death.

Director: After this certificate ! 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

State

31. Date filed (Month, Day

OCT 0 9 2012

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NPI:1598031205

GREENE ST. BALTIMORE, MD

OCTOBER 02 , 2012

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** October David 6th 2012 Michael /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT AGNESHOSPITAL BALTIMORE Baltimore City If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1<del>√</del> M 2□ F Months Days Hours 026-18-9625 86 Director 08/03/1926 MA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 23a or 28a-f show Examiner must be notified at MD Baltimore Co. Catonsville 1 ☐ Yes XX No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 719 Maiden Choice Lane 21228 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 or. 1 ☐Yes 2X No Specify: White þ 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene important: if item 27 is marked other the any Injury or other traumatic event, the once. 5+ Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Moakley 2 Burke Sarah Ann Upton Grady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8565 Trail View Drive Ellicott City, MD Mr. Warren J. Burke / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park: 10/11/2012 Elkridge, MD 21. Signature of Funeral S 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services, PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): 6 hours disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause Unionated events that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, neart 1 ☐ Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an s certificate has the lirector, page 2 s performe coagulopan 1 □Yes 2 🗖 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 6m2017. IMD P 27684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nare) Bhandon, 900 Cafe Avenue, Baltimor, MD.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bitterman 2012 Lawrence 04:05 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Martin House Baltimore Catonsville Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 560-54-0538 **Director** 1**XX**M 2 □ F Yrs 70 b4-16-1942 CA Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Maiden Choice Lane Funeral 21228 USA rral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: "natural" 3 Widowed 4 Divorced If Yes. Give Completed Specify: White Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Roman Catholic Priest Church Be 호통 17. Father's Name (First, Middle, Last) If Health and Merical fitem 27 is marked of 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ferdinad L. Bitterman Minnie Vienna 19a. Informant's Name/Relationship (Type, Print) Personal Rev. John Kemper, S.S. Rep. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 N. Paca Street Baltimore, Maryland 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State 1 Removal from State
4 Donation 5 Other (Specify) Sulpician Cemetery 10-09-2012 Baltimore, Maryland Funeral Servi Acensee 21. Sign were 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Examiner Secus tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical certificate be Box 68760 as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death
Unknown 5 Other (specify) Day detached Unknown P.O. signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy certificate 1 Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ဂ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DQA the Funeral Director; After this mpletely filled in by the funeral di 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 🗷 Natural 5 Pending death. 1 🗌 Yes 2 🗌 No Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: T. the cost of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of ertifier 0 Meara 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkens 31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death altimore 1103 al Security If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
May 23, 1939 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 1 **X** M 2 □ F Months Min **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore County 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 119 Patapsco Ave. 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. by 1 Never Married 2 Married Yes Yes, Give 2X No Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than United States Elementary/Seconday (0-12) College (1-4 or 5+) 10 Years Postal Service Mail Handler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Joseph Brune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 119 Patapsco Avenue Baltimore, MD Mrs. Dorothy L. Brune (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 Burial 2 X Cremation 3 Removal from cemetery, crematory or other place 5 Other (Specify) Hilltop Service Corp. 10/9/2012 Towson, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Marvland 21222 har Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Phylician disease or condition Medical resulting in death) Due to (or as nsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events and tra resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No Unknown signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗆 Yes 2 🗆 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy After this certificate 1 🗆 Yes 2 🗆 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ည 1 🔲 Yes DOA Longatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending ithin 24 hours after death.

• the Funeral Director; Aft

• mpleted filled in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

X DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Burnell Rita 11:55A M Barton-Godwin 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20 Shore Road Edgemere <u>Baltimore Co.</u> 8. Date of Birth Month, Day, Year March 8, 1943 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 😓 F Maryland Director 212-74-9429 69 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2 K No MD Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 20 Shore Road 21219 United States items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. o. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: "natural" 3 X Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lee Watkins Frances Vikel other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 222nd Street Pasadena, Maryland 21122 Pamela M. Tickle (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 ☐ Burial 2x ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 10/9/2012 Towson, Maryland 4 Donation 5 Other (Specify) . Signature of uneral Service Licensee Gress r 22 Dane and Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Vertnester Arrhythmic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner whic androvascer 13 Hypertensive Atherosch Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 2 5 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, it Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 [] 3 [] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D394660 Dreut Cil dut 8 2012

Registrar

HMH 17 Rev 7/2009

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21219

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year AROLYN 5:55 AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b, City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARY LAN MEDICALLENTEN BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 214-56-6772 **Director** 1 □ M 2 🖵 F 63 July 1,1949 MD Usual Residence of Decedent 28a-f show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🙀 Yes 2 🗌 No MD Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? event, the Medical Examiner must be 23a Funeral 516 N. Glover St. 21205 USA items ? 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2X Married ģ Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired)  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12th \end{array}$ College (1-4 or 5+) Operator Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Jertson Muse Betty L. James 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 516 N. Glover St. Balto, Md. 21205 Irving Stanley Banks 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Arbutus Mem.Park Oct 9,2012 Baltimore, Md of Funeral S 22. Name and Address of Facility
Calvin B. Scruggs Funeral Hame 1412 E. Preston St. Balto, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Depsis Medical resulting in death) Due to (r as a consequence of) **Examiner** -nracvanial Blee Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hodg kms Lymphoma Due to (ods a consequence of) Cause (Disease or injury that initiated events and the burial-tras resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown should be detached the 9 🗷 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsy performed' death? this certificate Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 Yes 2 No 1 ▶ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 🔀 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 624 hours a within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner To the basis of my moviking, death control at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) INTERLIN PHYSICIAN 12012 1699021378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar HEWRY M. AWDOH

31. Date filed (Month, Day, Year) -

2400 Clostnut St. #2405 Philadelphia 19103

Queren Burnett 12-07329

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

<del>UNK UNK</del>		- For State	Sta	te of Maryla		artment o <i>rtificate</i> o		d Menta	al Hygiene	Reg. No.	20	12 3222
Physiciar Medical Examin	1/	Registrar 1. Decedent's Name Queren	e (First, Middle, Burnett					•	2. Date of Month Septer		Year	3. Time of Death 0250 hrs
		4a. Facility Name (i University H		give street and no	umber)		4b. City, Town, or Baltimore	Location of	Death	40	c. County of D	eath
Funeral Director	- 1	5. Social Security N 220–31–59	87	5. Sex 1 M 2 X F	7. Age (In yrs. 35	last birthday) Yrs	If Under 1 Year Months Day	_		of Birth (MM. 16/19		Birthplace (State or preignTrinidad County St Indie
aryland 8a-f show any at once.	Director	Usual Residence of 10a. State MD 10e. Street and Nur	10b. County Prince	: George	10c. City Lau	, Town or Local rel	10f. Zip Code				izen of What (	
	= ŀ	8452 Sno		12. Was Dec	cedent Ever in U		20708 as Decedent of Hi 'es, specify Cubar			r No-		West Indies merican Indian, Black,
urs after deal fural", or it	ል .	3 Widowed  15. Decedent's Ec	4 X Divor	1 Yes ced If Yes, Give Yes or Dates:		1	Yes 2 No	specify:	nd of work done		B S <i>pecify:</i> Kind of Busine	lack ess/Industry
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1215-0036 Libe filed within 7 mal Hygiene. riked other than vent, the Medica	9	17. Father's Name ( Clyde Bo	cus		_			Rosit	Name (First, Mide a Ruiz			
MD 21 d 2 should 1 lth and Mer a 27 is man		19a. Informant's Na Clyde Boc				8452	Address (Stree Snowden	Oaks I	l., Lau	rel, M	MD 2070	08
imore, Pages 1 and ment of Heal lant: If the or other tra			X Cremation Other Spe	cify:	om Stata	arunde	l Cremat	ory 1	Date 0/08/20	12 O	denton,	
Balti permit. Departm Importa injury o		21. Signature of Fu	Eiph	<u>`</u>	M014							Service, PA 21227
Physician /Medical Examiner		23a. Part I. Enter th failure. List on! Immediate Cause (l or condition resultir Sequentially list cor	y one cause or Final disease ng in death)	a. <mark>Multiple Gu</mark>		nds	he mode of dying,	such as care	diac or respirator	arrest, sho	ock, or heart	Approximate Interval Between Onset and Death
uted d ansit	Examine	if any, leading to im cause. Enter Unde (Disease of injuly ti events resulting in o	mediate rlying Cause nat initialed	C.	consequence of	_			,			
	edical	UNPENDED		AMENDED			-			Las		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the build of Certification.	Siciany	F FEMALE: 3b. Was decedent past 12 months  1 Yes 2 N	?	1 Live b	nant at time of de	2 Fe	tal death 3 her <i>(Specify)</i>	Ectopic p	regnancy	234	d. Date of deli Month	Day Year
ords, P.O. Bover that the despect of the should be detached for the should	2	Part II. Other signif	icant conditio	ns contributing to	o death but not r	esulting in the ι	inderlying cause (	given in Part				e to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. Is an Attending Physician: The law requires that the safe reach.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Dataiduo							_	P	vas an utopsy erformed? es 2 N	prior death	
F Vital Rec Physician: The r this certificate cal director, page	B   3	25. Was case referr examiner? 1  Yes	ed to medical	Hospital: 1	Inpatient 2	ER/Outpatient		<u></u>	heck only one) lursing Home 5	Reside	nce 6 0	ther:
on of ading Ph. th.		27. Manner of Death		28a. Date (Mouth g Sep 27,	of Injury , Day, Year) 2012	28b. Time of I 1900 hrs		ry at Work? Yes 2 N	Subject		ury occurred	
Division o  Hospital or Attending 24 hours after death. Funeral Director: After the filled in by the fune	e Linear	2 Accident 3 Suicide 4 Homicide	6 Could determ	not be 28e. Plac	e of Injury - At he Sidewalk	ome, farm, stree	et, factory, office b	ouilding, etc.	or Tow	n. State)	nd Number or Ave, Baltim	Rural Route Number, City lore, MD
Di To the Hospital within 24 hours a To the Funeral 1 completely filled		Oncon only —		sician: To the besiner:On the basis and manner s	of examination a							
	NE P	eb. Signature and	title of certifier	eus)			29c. Licens			- 1	Date signed ( stember 28	(Month, Day, Year) 3, 2012
3v	T	Laron Locke	MD. Ass	ho completed cause sistant Medica		,	Iltimore Stree	t, Baltimo	re, MD 2122	3		
Stat	e	31. Date 1 ed Mont	9-20-2	32. Re	egistrar Signatu	Earl !			_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2012 Marian Bradley 7:40a 10 06 Medical 4a. Facility Name (if not institution, give street and number) b. City, Town, or Location of Death Baltimore **Examiner** 3017 Louisiana Ave. Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 01/20/1924 192-16-1492 88 Director 1 □ M 2 X F PA 28a-f shov 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 3017 Louisiana Ave. USA er than "natural", or items; the Medical Examiner mus within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes XXNo Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 7: nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Decorator 12 Factory other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Drew John Hanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1240 Delbert Ave., Dundalk, MD 21222 Marion Boehnlein / Daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 22 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date W. Arundel Crematory injury or 10/10/2012 permit. Page Department of Important: If any injury or Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physicin disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ■ No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🙅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) re and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0040491 10-08-2012

DHMH 17 Rev 06-2011

State Registrar 31. Date filed

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32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Beeler 2012 Rosella 9:15 Рм October 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care Ruxton Baltimore Ruxton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 25, 1920 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F 214-16-5257 91 Maryland Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be USA 21286 608 Stacy Court Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event. the M. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Lindner Anna Fischer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles W. Beeler, III/ Son 758 Villager Circle Baltimore, MD. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Ø ther (Specify) 3 ☐Removal from State |Dulaney Valley Mem. 10-9-12 Timonium, MD. 21. Signature of Funer Servic License 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DI nominara **Physician** /Medical Due to (or as a consequence of): Examiner of words Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Sepsis attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate 1∐ Yes 2 No Division or Vital Hospital or Attending Physician: 24 hours after death. this certifical 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 ☐ Pending investigation Injury the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiners: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 10-05-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TUWSONI po 2204 10V Jayant Usler arive M. D

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>012</u> Physician/ Month Helen Eunice Bailey October 7:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hill Top Assisted Living Rising Sun Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Min. Director 219-18-6319 1 □ M 2X F Maryland Usual Residence of Decedent Sep. 12 permit. Page 1 and 2 should be filed within 72 hours and ....
Depertment of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or itema 23a or 28e-f ahow important: If item 27 is marked other than "natural". 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 439 Aldino Stepney Road 21001 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 ☐ Divorced Year or Dates Decedent's Usual Occupation
 (Give kind of work done during most of working) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Heinz Nora Elizabeth Welsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 214 Mountain Hill Road, Perryville, Maryland 21903 Joseph Willis Jr./Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland Bel Air Memorial Gdn: 10/8/2012 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service Licensee lessee diseases 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ he disease or condition resulting in death) iner Medical Due to of as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) e Hospitel or Attending Physician: The lew requires that the death certificate be executed 24 hours effer death.
Funeral Director: Affer this certificate has been signed by the attending physician and letely illed in by the funear director, page 2 should be detached for use as the buriel-transit eletely illed in by the funear director, page 2 should be detached for use as the buriel-transit ig physician and as the burlei-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 Pregnant at time of death 9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, this certificate has been signal director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence of Other (Specify) 1 ☐ Yes 2 No Assisted ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of Living 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c 1 icense number

29d. Date signed (Month, Day, Y 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) min Christmet R039067 10/4/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janice Christine Schwartz, 998 Hospitality Way, Aberdeen, MD 21001 ÖCT 0 9 2012 32 Registrar's Signatu State Registrar

P.O.

12-07286 Charles Bryant

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ianes biyan		1-For State Certificate Certificate				2 0440
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)		Reg. 2. Date of Death		3. Time of Death
edical Exami	ner	Charles Bryant		Month D September 2	ay Year 26, 2012	1210 hrs
		Facility Name (if not institution, give street and number)     116 Crain Highway	4b. City, Town, or Location of Death	ì	4c. County of Death Prince George	'-
E		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Bowie  If Under 1 Year If Under 24Hrs	P. Data of Birth /	MM/DD/YYYY) 9. 8irt	
Funeral Director		148-42-7583	Yrs. Months Days Hours Min		Foreign	
и		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
d down	L	MD Prince Georges Bowie				1 Yes 2 X No
arylan 8a-f sl	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
ith the M 23a or 2 notified		16203 Penn Manor Lane  11. Marital Status 12. Was Decedent Ever in U.S. 113.	20716		USA	1 to 2
eath wi	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	
fter de		1 X Yes 2 No 3 Widowed 4 X Divorced of Pates:	Yes 2 No specify:		Specify: Bla	ck
ours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind of g most of working life. DO NOT use ret		6b. Kind of 8usiness/Ir	
36 n 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	quipment Operat		Constru	ation
J withing giene.	mo	17. Father's Name (First, Middle, Last)	<u> </u>	(First, Middle, Mai		
21215-0036 within 7 Mental Hygiene. marked other than c event, the Medical	Be	IInk	פווס	woon Dr	want Ton	es
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	7°	19a. Informant's Name/Relationship (Type, Print) Theodore Robinson III 19b. Ma		Rural Route Numbe	r, City or Town, State, MD 2071	Zip Code)
S l and of Heal		1 Rurial 2 X Cremation 3 Removal from State crematory of	position (Name of cemetery, r other place)		Oc. Location - City or	
Page Page ment o		4 Donation 5 Other Specify: Atlant	1	30/12	Glen Bur	nie MD
Baltimore, permit. Pages 1 an Department of Hea Important: If itelinjury or other tr			2. Name and Address of Facility Si Thomas Allen PA 7			Fun Serv
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ent				Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ardiovascular Disease			Between Onset and Death
		Sequentially list conditions,  b				
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
rd sit	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Box 68760, te death certificate be executed the attending physician and ted for use as the burial - transit	Medical E	d. UNPENDED AMENDED				
760, cate be physics the burn		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of delivery	
Box 687 death certific the attending p	cian	past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	ancy	Month D	ay Year
Box death the atte	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the control of the con	b	Part II. Other significant conditions contributing to death but not resulting in the Diabetes Mellitus	he underlying cause given in Part I.		cco use contribute to t	
cords,	Completed			24a. Was an		opsy findings available
tal Records cian: The law requi certificate has been ector, page 2 should	μŽ			autopsy performe	d? death?	ompletion of cause of
tal Rec ician: The l certificate l ector, page	0	25. Was case referred to medical	26.Place of Death (Check			2 140
Vita hysicia this co	O B	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpat	ient 3 00A Other Nursir	g Home 5 Re	sidence 6 🗸 Other:	Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the staffer death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	tion:	27. Manner of Death  1  Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time	of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe how	injury occurred	
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	street, factory, office building, etc.	28f. Location (Stre or Town, State		al Route Number, City
Hospita Hospita 4 hours Funeral		4 Homicide determined (Specify)  29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death or	ocurred at the time, date and place, and	due to the cause(s	) and manner as state	d
Divis  To the Hospital or A within 24 hours after To the Funeral Dire	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	igation, in my opinion, death occurred a	at the time, date and	I place, and due to the	cause(s)
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		entember 27 20	
		l amortalle	O.O.IVI.E.		September 27, 20	/12
21		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore, I	MD 21223		
St Regist	ate	31. Date filed (MOCTey) ear) 2012 32 Registrar's Signature	wed			

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:21 pm rene 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Funeral Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours -56-03 Director 1 M 2 MF -2permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Evaniner must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside £ity Limits Director imore 1 ✓ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3814 21207 USA HUENUR 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give and 21215-0036 1 Yes 2 No Specify Completed 3 ™ Widowed 4 □ Divorced Blac Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working

Ye. DO NOT use retired)

/ Letai Jales Mana 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Be 17-Eather's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 2/34/5/ CROS B Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD 4 Donation 5 Other (Specify) 10-16-2012 Darrison 21. Signature of Funeral Service Licenses Funeral Services MD21133 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastalic cancer Medical Examiner 30 day 1 tastatic Neuro endocrine Tumour Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physicien end detached for use es the burial-tren that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day 1 Yes 2 D 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be de 23e. Did tobacco use contribute to the cause of death? by Thrombocytopenia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Director: After this certificate I d in by the funeral director, pag perform 1 Yes 2 No Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Mother (Specify) MOSPICE Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 24 hours after de Funeral Directo letely filled in by tl Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License numbe NAPLE RES 000 OCTOBER 6 -2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NACHIKET MBBS MOSPITAL SINAL BALTIMORE 21215

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#26perpHYS G932 10/9/2012 WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ 2012 Oscar Adrian Cronk Jr. Oct 12:00P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Westminster Ridge Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 230-12-6256 **Director** 1X M 2 □ F 88 6-2-1924 VA or than "nature!", or items 23a or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Clarksville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5666 Chamblis Dr. 21029 USA 11. Marital Status 12. Was Decedent Ever în U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Scout Executive Youth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be filled Mental Oscar Adrian Cronk Sr. Daisy Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Cronk Terry-daughtet 5666 Chamblis Dr., Clarksville, MD Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pege 1 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 10/6/12 Sykesville, MD 21. Sign tu e of Funeral Service Licensee 22. Name and Address of FacilityFletcher Funeral & Cremation nomas 7 21157 Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death - diorpse-inlar Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed To the Hospitai or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran. that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760  $\angle$ Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wiknown - Che mus 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Assisted Certificate: To 1 🗆 Yes \_2 □No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) iving 27. Mannef of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: Jethe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 005016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 post

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Certificate of Death	R	eg. No. 2012 32233
	Physicia	an/	Decedent's Name (First, Middle, Last)		2. Date of Death	
1,54	Medic Examir		Doreen M. Crawford  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	October	
ز	ZAGITIII		Doctors Community Hospital	Lanham	aut	4c. County of Death Prince George's
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last bir			Birthplace (State or Foreign
	Director		128-82-2937 1 ☐ M 2 XF 81	Yrs.	Aug. 28	
	land show	ţ		n or Location		10d. Inside City Limits
	Mary 28a-1 otifie	Director	MD Prince George's Riverd	ale		1 X Yes 2 □ No
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at	ra D		10f. Zip Code	1	0g. Citizen of What Country?
	ems 2	Funeral	6612 Patterson Street 11. Marital Status 12. Was Decedent Ever in U.S.	20737  13. Was Decedent of Hispanic Origin?		JSA
92	fter de , or it	ē	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
00	ours at tural" al Exa	ted	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No Specify:		Specify: Black
15	<u>e</u> - <u>9</u>	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired)	vorking	16b. Kind of Business/Industry
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nd	be filed wil ental Hygie ked other ic event, the	To Be	17. Father's Name (First, Middle, Last)		lame (First, Middle, Ma	aiden Surname)
ryla	should be fill and Mental is marked or aumatic eve	۳	Unknown	Alfrid		
Mai	2 shou th and 27 is m traum		1	o. Mailing Address (Street and Number or I		
ē	1 and 2 s if Health item 27 other tra			612 Patterson Stree		Le, MD 20737 20c. Location - City or Town, State
E O	Page nent o int: If		1X Burial 2 Cremation 3 Removal from State cemete	ry, crematory or other place) tional Cemetery 10—	- 1	aurel, Maryland
Baltimore, Maryland 21215-0036	permit. Page 1.8 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	.B. Jenkin	s Funeral Home, Inc.
			23a. Part 1. Enter the disease or complications that caused the death. Do r			sville, MD 20785
-m_ 8	Ph_sician/		snock, or heart failure. List only one cause on each line.  Immediate Cause (Final		ac or respiratory arres	t, Approximate Interval Between Onset and Death
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	sit sd	Examiner	if any leading to immediate partial Due to (or as a consequence), cause. Enter Underlying			
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8760	tificate ng phy as th	Medical	IF FEMALE:			
× 6	ath certi attendin I for use		23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 Live Birth 2 Fetal death			23d. Date of delivery
Division of Vital Records, P.O. Box	Hospital or Attending Physician: The law requires that the death cer 24 hours after death. Funeral Director: After this certificate has been signed by the attendictely filled in by the funeral director, page 2 should be detached for use	Physician/	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month Day Year
P.0	that the red by seta	by Pt	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
ds,	requires that the des been signed by the s should be detached	ed k	Renal Failure		_ 1 ☐ Yes	2 No 3 Probably 4 X Unknown
COL	aw rec as be	Completed	Carotid Stenosis S/P Carotid Endar	terctomy	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Re	<b>hysician:</b> The law nis certificate has b I director, page 2 s		Below Knee Amputation Peripheral V	ascular Disease	perform	ed? death?
ta	sician certifi irecto	0	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 FR/Out	26. Place of Death (Ch		
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ono	tending leath. tor: Afte the fun	ficat	1 X Natural 5 Pending (Month, Day, Year) in 2 Accident Investigation	mjary occurred		
Visi	or Atter frer de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number,
Ō	pital o		29a. Certifier 1 XCertifying Physician: To the best of my knowledge			
	e Hos 124 ho e Fun eletely	Nedical	29a. Certifier (Check only one)  1	r investigation, in my opinion, death occurred	at the time date and	place, and due to the cause(e) and manner stated
1	To the Hospital or Atte within 24 hours after der To the Funeral Directol completely filled in by th	Σ	COL CI washing and title and a City			
			Xacey Ahmad.	26021		10-7-2012
_			30 Name and address of person who completed cause of death (Item 23a) (1	Type, Print) anover Parkway	1. 1.	14 mD 2
	Stat		JR. Lageeg Hhm and 7335 H 31. Date filed (Month, Dky, Year) 32. Registrar's Signature	anover Parkway	ween be	T 1111/1 20770
	Registra	9	OCT 0 9 2012 Severa B. A.	ake '		

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #11 per spouse G934 12/12/12 dk

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First\_Middle\_Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 04 2012 STANLEY CHERTOCK 9:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUNRISE ASSISTED LIVING COLUMBIA HOWARD Social Security Number 6. Sex **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 078-18-4642 **Director** 1 X M 2 - F Yrs. 87 12/18/1924 NY Usual Residence of Decedent ortant: if item 27 is marked other than "natural", or items 23e or 28e-f show injury or other treumetic event, the Medical Examiner must be natified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No HOWARD CLARKSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6117 SWIFT CURRENT WAY 21029 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 Yes 2 A No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 X Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 V Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4 or 5+) RECONSIDERATION SPECIALIST ADMINISTRATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAMUEL CHERTOCK MINNIE FEINSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth 8 ALISON HEALY/DAUGHTER 6117 SWIFT CURRENT WAY, CLARKSVILLE, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pege 1 e Depertment of H Important: if ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MOSES MONTEFIORE CEM: 10/07/2012 BALTIMORE, MD 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part . Enter the diverse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail in . List only one cause on each line. Approximate Interval Between Onset and Death theroschosi's Immediate Cause (Finds Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The lew requires thet the deeth certificate be executed within 24 hours after cleath.

To the Funeria Director: After this certificate has been signed by the ettending physicien and completely filled in by the funneal director, page 2 should be deteched for use as the burlei-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 Unknown 2 No g Unknown ete has been signed i pege 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? autopsy perform Yes 2 N 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ASSISW CIVA 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier MD ddress erson who complete discause of death (Item 23a) (Type, Print) o lembio Lane 31. Date filed (Month, Day, Year) State Registrar

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 17. 201.2 11:05 PM Gabriele M. Chenoweth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 220-62-7137 Director 1 □ M 2 🖾 F 68 June 6, 1944 Germany Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1209 Walters Mill Road 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: white Completed 3 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) healthcare registered nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karl-Heinz Bahike Marianne Schultze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Walters Mill Road Forest Hill, MD George D.B. Chenoweth/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signatur of Euneral Sin ce Licen 23-Name and Address of Feeling oard 655 W. Baltimore Street Me, Director 21201 Baltimore, MDPart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 cor. After this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the GRABIELLE CHENOWETH IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 X No Month Dav Year 1 Yes 2 U 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 Tes 3 Probably 4 Unknown Νo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) HOSPICE 1 Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY JACKIE JONES, **CRNP** VALLEY RD TIMONIUM, MD 21093

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State Registrar

31. Date filed (Month, Day

2012

SEPTEMBER

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Day 01. Month October 10:59am Yuan-Who Chen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Shady Grove Adventist Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 462-71-3669 1X M 2 D F 12/12/1954 Taiwan Usual Residence of Deceden a Hygiene. I other than "natural", or Items 23e or 28e-f show vent, the Medical Examiner must be notified at 10b, Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Gaithersburg 1 ☐ Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20879 U.S.A. 18406 Honeylocust Circle 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ۾ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Asian 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Mathematician Federal Government 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hanqi Chen Ma Yu-Zu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18406 Honeylocust Circle, Gaithersburg, MD 20879 Pege 1 end 2 Allshine Chen - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 of Papertment of Papertment of Papertment: If Ite any injury or ot once. 1 D Burial 2 Cremation 3 Removal from State 10/12/2012 Germantown, Maryland All Souls Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of select line. Immediate Cause (Final Onset and Death Physician/ Metastatic Adeno Carcinoma disease or conditi-resulting in death) Medical Due to (or as a consequence of): Examiner vimonary Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying Cause (Disease or injury  $Ch\,eh$  ,  $\sqrt{\cup\,a\,\mu}$  Division of Vital Records, P.O. Box 68760 Hospitel or Attending Physicien: The lew requirss thet the deeth certificete be executed L5 lumbar nontraumatic spine complession facture ettending physicien end I for use es the buriei-tren that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day sete hes been signed by the e pege 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ XProbably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? After this certificate 1 ☐ Yes 2 ☐ No burs efter death. eral Director: After this certificaliled in by the funerel director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 🖎 No |<u>|</u>2 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours e Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 64502 who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pau1 Wesley Cotherman, Sr. Oct. 2012 3:38 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2105 Searles Road Dundalk 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Hours Min. Director 219-50-2035
Usual Residence of Decedent 1 X M 2 F 65 Feb. 15,1947 Maryland show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2 XNo Dunda1k Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be **23**a Funeral 21222 2105 Searles Road United States ural", or items a I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, was beceden Ever III 0.3.
Armed Forces?
1 ▼ yes 2 □ No
If Yes, Give
Year or Dates.Vietnam Black, White, etc. þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or lury or other traumatic event, the Medical Examil ury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Years Property Manager Apartment Complex Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Carl David Cotherman, Sr. Virginia Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland Mrs. Mary P. Cotherman (Wife) 2105 Searles Road 21222 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 X Cremation 3 Removal from State Department o Important: If any injury or 4 ☐ Donation o ☐ Other (Specify) Kop Service Corp: 10/9/2012 Towson. Maryland charles 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Small Immediate Cause (Final Onset and Death una Cancer Ph\_sician/ Metas one winter disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Cause (Disease or injury that initiated events and the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has page 2 After this certificate 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Chec Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only o 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39 Name and address of person who completed cause of death (Item 23a) (Type, Print) a Road # 208, Saltimore, MD 2837 31. Date filed (Month, Day, Year) 32. Registrar's State

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Registrar

2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6,2012 Betty Dolle 1:30a м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 327 2nd Avenue Baltimore Lansdowne 8. Date of Birth (Month, Day, Year) March 30, 1930 . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Hours Mary Land **Director** 217-24-1064 1 M 2 X F 82 Usual Residence of Dec filed within 72 hours efter death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Lansdowne 1 🗆 Yes 2 💢 No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 327 2nd Avenue 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Armed Forces?

1 ☐ Yes 2 【 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 🙀 Widowed 4 🗆 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o Ralph Keffer Virgie Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai Carl Dolle/son 327 2nd Avenue Lansdowne, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory or other place) Baltimore, Maryland 10/9/2012 22. Name and Address of Facility Cremation Society of Maryland, Inc 21. Signature of Fundral Service LicenseStephanie Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ a. END STAGE LUNG CANCER 0 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag performe 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0054739 OCTOBER 9th 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21061 GAKWOOD SUITE MO RO GLEN BURNIE 204 31. Date filed (Month, Day, Year) 32. egr Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Kimberly Dalesandro 1249 AMM 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** n/a 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 👽 F Director 213-84-3210 Jan.15. 1960 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified at 10a State 10h County 1 ¥ Yes 2 □ No Director Maryland n/a Baltimore City 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or Examiner must be 21224 615 South Streeper Street USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white 2 3 Widowed 4 Divorced Year or Dates: 'naturai", Completed 16b. Kind of Business/Industry marked other than "natur matic event, the Medical 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental F John D'Alesandro permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked, any ligity or other traumatic evance. Dorothy Drez ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bruce Dody/husband 615 South Streeper Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 10/9/2012 5 Other (Specify) Baltimore, Maryland 4 Donation of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 the disease, or comp Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Ente shock, or heart failure. List only one cause on each line. Preumonia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Examine Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events attending physician and I for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2/ No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) Injury after death. Director: Aft 1 ☐ Yes 2 ☐ No the 1 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide filled e Funeral I

State Registrar 29a. Certifier

one)

(check only

29b. Signature and title of certifier

31. Date filed (Monthy Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001 11595

the Hospital

within 24 hou To the Funer completely fil

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Edward F. Duschl  $\mathbf{P}^{\mathsf{M}}$ 2012 Medical October 6. 6:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1500 Chesapeake Road Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days **Director** November 16, 220-30-0744 **77** Yrs. Balt., Maryland 1934 23a or 28a-f show and Mental Hygiene.
'is marked other than "natural", or items 23a to the confidence of the Medical Examiner must be notified at 10b, County 10c. City, Town or Location **Funeral Director** Maryland Baltimore Baltimore 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **United States** 1500 Chesapeake Road 21220 America 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1XXYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: white Completed 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City 12 Housing Inspector Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i and 2 should be fil I Health and Mental Item 27 is marked မှ Michael Duschl Johanna Uhl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs. Ruth E. Duschl/ wife 1500 Chesapeake Road Baltimore, Maryland 21220 Department of Healtl Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October Evans Funeral 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 9, 2012 Chapel -Bel Air Signature of Foneral Service Lice 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a/ Part 1. Inter the disease, complications that caused shock, or heart failure. Lin only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Yes 1 Yes 2 L 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 🗌 Yes 2 🗌 No Yes 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer use of death (Item 23a 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Physician/ DeMarco 2012 Debora Ann 10 06 02:35 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 116 Holly Circle Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 213-68-4518 **Director** 1 M 2 X F 56 Yrs 12/18/1955 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 X No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ms 23a or must be n Funeral 21221 U.S.A. 116 Holly Circle tems within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian an "natural", or iter Medical Examiner Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4 or 5+) filed within al Hygiene. Senior Administrative Asst. Utility Property of the second Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy important: If item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bettien Dolores Lease William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. DeMarco, Jr., Husband 116 Holly Circle Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Dulaney Valley Mem. 1 K Burial 2 Cremation 3 Removal from State 10/11/12 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final meast canco Physician/ nonth metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Date to for as a consequence of Examin resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an

Division of Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the after death. page 2 should this certificate has the funeral director, e Hospital or Attending Ph 24 hours after death. e Funeral Director. After th To the Hosp within 24 ho To the Fune completely f

2 NI 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 \( \square\) Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manual of Death 28b. Time of 28c, Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending Accident
Suicide Investigation

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aud Bourse D0058893 Octobron 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltonere UNO 21224 Bayren Cicle L02 5505 Hopkers

State Registrar

Be

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Certificate:

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32242 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 01 2012 0252 M John Francis DeVries, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Funeral (Month, Day, Year) Months Days 217-42-7805 Director 1 XM 2 - F 09/29/1945 Washington, DC 67 ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits death with the Maryland Director Rockville 1 Yes 2 No Maruland Montgomery 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20850 716 Crabb Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married à Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Caucasian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Law Enforcement Police Officer æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be Mary Eagleston John Francis DeVries, Sr. .t. Page 1 and 2 shou...
•• of Health and Me
•• of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Crabb Avenue, Rockville, Maryland 20850 Connie M. DeVries - Spouse Department of Heali Important: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 10/10/2012 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 21. Sign ture of Funeral Service-Licensee 1040 Rockville Pike, Rockville, Maryland 20852 er Rart 1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ ease or condition Medical resulting in death) Due to (or as a consequence of): Examiner or rator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed osi attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Recta -010 Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 1 Yes 2 No 24 hours after death.

• Funeral Director. After this certificate has been signed by the siletely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) melian October 2,2012 D0064478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Ofr Dr Rochville, his 20850 9901 MD Fischatsion 31. Date filed (Month, Day, Year) State OCT 0 9 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Saltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 ★ M 2 □ F Hours Min (Month, Day, Year, **Director** 220-14-7377 05 25 Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No MD NA Baltimore 10g. Citizen of What Country? ò 10e, Street and Number 10f. Zip Code items 23a Funeral 2108 Poplar Grove Street 21216 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married 'natural", or 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12th grade Photographer Dept. of Justice permit. Page 1 and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mark A. Dungee Lilda Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 Md 2108 Poplar Grove Street, Joyce Dungee-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 10/9/2012 Memorial Arbutus, Arbutus 22. Name and Address of Facility larch F/H West 300 Wabash Av March Baltiore Ave 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine death certificate be executed the burial-transit OURDI Due to (or as a consequence of) attending physician Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy 2 🗹 No certificate 2 No 1 Yes 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this ( 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury ✓ Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F only one) 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

2012

Box 68760

P.O.

			State of Maryland	Department of Health and M	lental Hygier	ne	
			1 - State Registrar	Certificate of Death	Reg.	No. 2012 32244	
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last)  SHELDON B. DUNC	CAN	2. Date of Death Month	Day Year 2012 2:3% A M	
)	Examin		4a. Facility Name (If not institution, give street and number)  MED STAR ITAK BOR HOSD TA	4b. City, Town, or Location of Death		4c. County of Death N / A	
	Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last b	pirthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign	
	Director		215-28-7692 1⊠M2□F 80	Months Days Hours Min.	(Month, Day, Yea May 2, 1		
	nd <b>how</b> at	٦c	Usual Residence of Decedent           10a. State         10b. County         10c. City, To	own or Location		10d. Inside City Limits	
	faryla 3a-f s tified	Director	Md Anne Arundel Broo	klyn Park		1 ☐ Yes 2 <b>X</b> ☐ No	
	or 28		10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?	
	n with	Funeral	606 Brian Street	21225	U.	.S.A.	
36	ge i and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates,	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F  1 ☐ Yes 2 ☒ No Specify:		14. Race - American Indian, Black, White, etc.  Specify: White	
9-0	hours natur Iical B	lete	15. Decedent's Education 16	6a. Decedent's Usual Occupation	16b	b. Kind of Business/Industry	
21	nin 72 ne. han " e Mec	omp	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done during most of working life. DO NOT use retired)			
121	d with lygier ther t	Be C		elephone Tech		ucent Tech	
anc	oe file antal F ced oi	0	17. Father's Name (First, Middle, Last) Thomas Duncan		(First, Middle, Maid Wheatly	,	
ary	nd Me nd Me mark			9b. Mailing Address (Street and Number or Rural			
ž	d 2 shalth a			01 Three Coin Way			
ore,	of He			e of Disposition (Name of Detery, crematory or other place)	ate 20c	. Location - City or Town, State	
<u>Ĕ</u>	Page 1 ment of lant: If it		I Dunai 242 Olemation 3 Li Removal nom State	intic Cremation 10/5	/2012 G	len Burnie. MD	
Baltimore, Maryland 21215-0036	permit. Page 1 al Department of H Important: If iter any injury or oth		21. Signature di Funeral Service Licensee M00-732	McCully Polyniak 1237 E. Patapsco	Funeral	l Home, P.A.	
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			Approximate Interval Between	
7	Ph_sician/ Medical	j 01	Immediate Cause (Final disease or condition resulting in death)		NOMA	, Onset and Death	
	Examiner		Due to (or as a consequence	e of):			
	d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	death certificate be executed re attending physician and ed for use as the burial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	e of):			
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9289	tificate ng phy e as th	Med	IF FEMALE:				
Box 6	ath certifica attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 2 No 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de 4 Pregnant at time of death			23d. Date of delivery  Month Day Year	
B	he deg y the g ached	hysic	1   Yes 2 No 9   Unknown	1 3 Li Ottlei (specily)		,	
P.O.	es that the dea signed by the a l be detached f	by P	Part II. Other significant conditions contributing to death but not resultin	g in the underlying cause given in Part I.		co use contribute to the cause of death?	
ds,	requires been sig	ted			1 🗌 Yes	2 No 3 Probably 4 Unknown	
ecol	The law re ate has be page 2 sh	Completed			24a. Was an autopsy performed		
al B	an: Th tificat tor, pi	Be C	25. Was case referred to medical	26. Place of Death (Check	1 Yes 2	No 1 ☐ Yes 2√≦ No	
<b>Vit</b>	nysician: T	TO E	examiner? 1	Outpatient 3 DOA Other: 4 Nursing Hor	me 5 🗆 Residence	e 6 ☐ Other (Specify)	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Certificate:	1   Natural 5 □ Pending (Month, Ďay, Year) 2 □ Accident □ Investigation	b. Time of injury M 28c. Injury at work?  M 1  Yes 2 No	28d. Describe how in	jury occurred	
Divisi	al or Att s after d al Direct ed in by		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	he Hospital in 24 hours a he Funeral I ipletely filled	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination and 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination and only one)	d/or investigation, in my opinion, death occurred at t	the time, date and pla	ace, and due to the cause(s) and manner stated.	
	To the within To the comple		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)	
)			30. Name and address of person who completed cause of death (Item 23a K ' S ト D HA RM AS ENA , M・):	3721 POTER STRE	ET, BALT	(MORE, M) 21225	
	Stat Registra		31. Date filed (Month, Day, Year)  Registrar's Signature				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER ELLIOTT **EPSTEIN** 01:35 R. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON 8. Date of Birth (Month, Day, Year) 09/24/1920 **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Country) 219-05-6207 1**X**X M 2 □ F Director 92 MD 2 should be filed within 72 hours efter death with the Maryland the and Mental Hygiene.
27 is merked other then "neturel", or items 23e or 28e-f shov treumetic event, the Medical Evertaint must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT. WILSON LANE, APT. 311 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 □ Yes 2 □ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 + SCHOOL PRINCIPAL **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ J0EL **EPSTEIN** SADIE SCHECHTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s of Heelth e item 27 i permit. Page 1 end 2 Department of Heelth importent: if item 27 eny injury or other ti JANE EPSTEIN/DAUGHTER 2209 OXEYE ROAD, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CEMETERY 10/07/2012 FINKSBURG, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Preum disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ettending physicien end I for use es the buriel-trensif Cause (Disease or injury that initiated events The law requires that the death certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year ed by the e 1 Yes 2 No 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? Completed by Division of Vital Records, CONGESTIVE HEART FAILURE 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available 24a. Was an has prior to completion death? ours efter death. erei Director: After this certificate I filled In by the funeral director, pag HYPORTONSION 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospitei or Attending Physicien: 24 hours efter death. 25. Was case referred to predical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospitei within 24 hours e Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number of death (Item 23a) (Type, Print) ss of person who completed cause OCT 0 9 2012 Registrar

Registrar

Box 68760

P.O.

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1:30 AM M October 2012 Chervl Ann Fleming Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1205 Boyd Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours Min. March 9, ¶969 New Jersey **Director** 1 M 2 X F 50-56-4895 43 show or 28a-f shove e notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 21154 United States 1205 Boyd Road "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **XX**No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXNo Specify: 3 Divorced 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Special Needs Education Inclusion Helper 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Patricia Ann Tyrrell Thomas W. Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and Comportant of Health and Important: If item 27 is Comportant or other transcriptory 1205 Boyd Road Street, Maryland Shawn H. Fleming / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 6, 1 Burial 2 K Cremation 3 Removal from State Evans Funeral drapel 2012 Forest Hill, Maryland 4 Donation 5 Other (Specify) Bel Air f Ineral Selvice Licensee Evans Funeral Chapel & Cremation Service-BelAir Forest Hill, Maryland 21050 3 Newport Drive 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Onset and Death liver Immediate Cause (Final Physician/ concer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🔎 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Director; A Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tite of c 29d. Date signed (Month, Day, Year) D0066992 10 ron 6 gm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Venkata P<u>arsa</u>, 510 Upper Chesapeake Drive, Bel Air, Maryland 21014 31. Date filed (Month, Day, Year, 32. Regist OCT 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e \$19b Per FH G932 10/19/2012 Jh State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gale 2012 10:10A M wae Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Battemones Hospice center Towson If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 216.06.0521 **Director** 1 M 2 XF MD 13 1982 'Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Charme1 Funeral 21244 Drwe USA ama Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Black Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager 12th grade 24 ears Be 17. Father's Name (Pirst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည M. Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charmel Windsor Mill MD 21244 (Husband Gale Drive Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Woodlawn, MD 13/2012 Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) 10 . Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral services Vaug 87281 Bandallstown MD 21133 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or hear, failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of): burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last e Hospital or Attending Physician; The law requires that the death certificate be exe 24 hours after death. 94 hours after death. 9 Funeral Director, After this certificate has been signed by the attending physician a the attending physician the for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: To the Funeral Director: After this certificate has been signed by the attendin, completely filled in by the funeral director, page 2 should be detached for use a yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 🗌 Yes မ 2 X No Hospi 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Certificate: 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 Pending injury Investigation 3 
Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. O Ter Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Cat lifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) Signature and title of ertifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V nae 191 31. Date filed (Month, Day, Year)

OCT 0 9 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ BERNARA 10:30 A.M GABRIEL October 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Exeter South TIMORE Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral Director** 1 **X** M 2 □ F 58 179ND 28a-f show 10b. County 10c. City, Town or Location nside City Limits Examiner must be notified at Director 1 Yes 2 ☐ No TIMOSE MACYLAND 10e. Street and Number ò 10g. Citizen of What Country? 23a U-S-A 21202 Exeter items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceue... \_ Armed Forces? ¹ ☐ Yes 2 No 14. Race - American Indian. Black, White, etc. ö Never Married 2 Married b Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates "natural". 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 7. of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) GABRICLE permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, f Be 17. Father's Name (First, Middle, Last) မ GARRIELE 200 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, heresA 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9-201Z 4 ☐ Donation 5 ☐ Other (Specify) Dedeemen 22 Name and Address of Facility l RE 23a. Part 1. Enter the disc or complications that caused the death. Do not enter the mode of dying, such as cardia's Approximate shock, or heart failur. List ou Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death detached the g 🗌 Unknown P.O. ģ been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Hospital or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No 2 Nursing Home 5 Residence 6 C Other (Specify 1 Inpatient 2 ER/Outpatient 3 I funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) enblat+ trabeth 16 31. Date filed (Month, Day, Year) Registrar **OCT 0 9 201** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32250 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Physician/ 2012 Griffin 26 5:20A Willie Eugene Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Arcola Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year) 228-40-8788 **Director** 1 🛛 M 2 🗆 F 91 S.C. 04/30/1919 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No DC Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20011 USA 4617 North Capitol St. NE 12. Was Decedent Eyer in U.S. Armed Forces? 1941— 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1946 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Defense Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Equipment Specialist Department of 10 permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event \*\* Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P Charles Griffin, Jr. Rosanna Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Griffin/Wife 4617 North Capitol St. NE Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Quantico National Cem. 10/05/2012 Triangle, VA 21. Si ma ire of Funeral Service Licen 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 a. Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition vears Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the 88 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown the be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No page 2 1 Yes 2 X No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 XNursing Home 5 A Residence 6 Other (Specify 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certified

31. Date filed (Month, Day,

OCT 0 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

Barry N. Rosenbaum, M.D.,

P.A.

29c. License number

D09834

3720 Farragut Ave. Kensington, MD 20895

29d. Date signed (Month, Day, Year)

10/02/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:26 AM Medical Rebert Alvin Coodspeed
4a. Facility Name (if not institution, give street and number) 201 Oatober Examiner 4b. City, Town, or Location of Death 4c. County of Death Golumbi If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min Sunrise Assisted Living Facility 9. Birthplace (State or Foreign Funeral . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Country Director 1 🕱 M 2 🗆 F 78 Yrs. North Dakota Feb 06, 1934 ence of Deceden 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f sho 10a. State ral", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? Funeral 6500 Freetown Road 21044 Inited States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Force Completed by 1 Never Married 2 Married 1 X Yes 2 No altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Year or Dates. QC White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Covernmen Analist other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alvin Ambrosius Goodspeed Hildur Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tim Goodspeed /Son River Run Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 D Burial 2 A Cremation 3 D Removal from State Oct 09, 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility M01443 Cremation and Funeral Alternatives 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burlal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie

DHMH 17 Rev 06-2011

State

Registrar

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Registrar's Signature

Colubia Mary

person who completed cause of death (Item 23a) (Type, Print)

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OCT 09

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Francis Aaron Green 11:10 a<sub>M</sub> October 201<sup>x</sup>2<sup>a</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 205 St. Mark Way Apt 225 Westminster Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months (Month. 219-14-7918 Dec 23 1923 **Director** 1 X M 2 □ F MD 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10h Count 10c. City, Town or Location Funeral Director 10d. Inside City Limits MD Carrol1 Westminster 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 205 St. Mark Way Apt 225 21158 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 NoWWII

If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Nidowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) BGE College (1-4 or 5+) appliance supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Aaron Arthur Green Marjorie Mae Babylon 19a. Informant's Name/Relationship (Type, Print) Mr. Wayne Green (son) 4630 Skyview Dr., Glenville, PA 17329 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lake View Memorial 10-11-12 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dauge Haught Sterbert P.O. Box 195 Sykesville, MD\_21784 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscleratic Immediate Cause (Final Physician/ Coronary disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 <Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for in the past 12 months' Pregnant at time of death Month Day Year 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify 2 1 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar

0

RICKETTS MD 910 Washington Rd Wostminster MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (ifvno institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's 5605 Patagonia Court Clinton If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Director 1**X** M 2 □ F 577-58-1243 65 Feb. 2, 1947 Washington, DC 2 should be filed within 72 hours efter death with the Maryland the end Mentel Hyglene.
27 is merked other then "neturel", or items 23s or 28s-f show treumetic event, the Medical Exeminer must be notified at 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Prince George's **Clinton** MD 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funerai 5605 Patagonia Court 20735 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government 12th Financial Revenue Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrie Lyles Ear1 Gwynn . Pege 1 end 2 should b ment of Health end Mer tent: If itsm 27 is merk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7505 Foxcroft Pl. Clinton, MD 20735 Irving Gwynn Jr./Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pege 1 e Depertment of H Importent: If its eny injury or ot 1 K Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 10-12-2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 21. Signature of Funeral Service Licensee Naphney 7474 Landover Road Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. UNG Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ettending physicien end I for use es the burlei-trensit or Attending Physicien: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) been signed by the e should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an pege 2 autopsy perform hes certificete Yes 2 25. Was case referred to medical examiner? filled in by the funerel director, 26. Place of Death (Check only one) æ ne Hoapitel or Atternation 24 hours efter deeth. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **N**o <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospitel within 24 hours (To the Funeral Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 0 ath (Item 23a) (Type Print

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year NA 2012 0641 AM Y tobei Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner ndoulstown 1+1more Count Pita1 9. Birthplace (State or Foreign Country) NY 7. Age (In yrs. last birthdav If Under 24 Hrs 8. Date of Birth **Funeral** Hours 1 □ M 2 🛛 F 102-14-3092 91 Yrs. 09/02/1921 Director Usual Residence of Decedent 28a-f shov at 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland Director must be notified 1 Yes 2 X No MD HARFORD BEL AIR 10g. Citizen of What Country? 0 10e. Street and Numbe 10f. Zip Code 23a Funeral USA 21015 2110 FAIRLANE ROAD or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🎇 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE SUN NEWSPAPER REPORTER traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o မ GREEN ANNIE MINTZER HYMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 ALEXANDRA BLVD., CRYSTAL LAKE, IL 60014 MARK GOLDBERG/SON Baltimore, other. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 10/05/2012 4 Donation 5 Other (Specify) BETH DAVID CEMETERY ELMONT, NY SOL LEVINSON & BROS., INC. Signature of Funeral 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition VI Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events Examine Due to (or as a consequence of): -transit and Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as 1 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? hours after death. Ineral Director: After this certificate 25. Was case referred to medica filled in by the funeral director, 26. Place of Death (Check only one) Be Other: မ 1 Yes 2 No 1 Inpatient 2 Z ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5  $\square$  Pending injury work' 1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical obeAt Month 5 55 PM 2012 4a. Facility-Name (if not institution, give street and number) **Examiner** 4c. County of Death NKton DAILIMORE 45ING 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 218-60-3393 Country) Director 1 🔀 M 2 🗆 F unk 59 Usual Residence of Decedent Oct 3, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 1701 Eutaw Street #517 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "not any injury or other than "not any i 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No If Yes, Give unk 1 ☐ Yes 2 🔀 No Specify: Specify: black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frankford Nursing Home 5009 Frankford Avenue Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Å Other (Specify) In State 21. Signature of Funeral Service Licensee

LORd Id S. Node, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ LIVER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown eral Director: After this certificate has been signed filled in by the funeral director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has autopsy 1 ☐ Yes 2 ☐ No ☐ Yes\_ Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Universing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and th 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walthan Woods Ad 8813 HOLLAND 31. Date filed (Month, Day, Year) 2. Registrar's Signa State OCT 0 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 1 Physician/ Edward Andrew Gross 1943 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-76-7941 Director 1 ₺ M 2 🗆 F Yrs 09/10/1952 60 Maryland or items 23a or 28a-f showing the must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Laurel Maruland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8814 Church Field Lane 20708 U.S.A. Page 1 and 2 should be filed within 72 hours after death v ment of Heelth end Mental Hyglene. ant: If Item 27 Is marked other then "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 X Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 3 Divorced Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marian Virginia Schmidt John Edward Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nan C. Donnells - Sister 14709 Chisholm Landing Way, N. Potomac, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 e
Depertment of H
Important: if ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 09/27/2012 | Brentwood, Maryland 21. Signatur of Fuderal Service Licenses 22. Name and Address of Facility Simple Tribute Funeral & Cremation Cente 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 52 Years Immediate Cause (Final Physician/ disease or condition resulting in death) Dawson's Encephalitis Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami After this certificate hes been signed by the ettending physician end inference, the buriel-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the eftending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day 1 Yes 2 No g | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier avid Mente ce4 heff, JUD 20770 31. Date filed (Month, Day, Year) State OCT 0 9 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ October 06. Karen Arlene Goldberg 2012 2:35 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Director 215-72-7547 55 10/29/1956 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be nothing an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maruland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6513 Danville Court U.S.A. 20852 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ۾ 1 Never Married 2 X Married 1 ☐ Yes 2 🂢 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Director of Smart Sacks Non-Profit Food Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Cole John William Talbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Goldberg - Spouse 6513 Danville Court, Rockville, Maryland 20852 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 10/12/2012 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinalli Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Breast Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The lew requires thet the death certificete be executed Cause (Disease or injury ate hes been signed by the attending physicien end page 2 should be detached for use as the burlal-tren that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate hes autopsy performed? 1 ☐ Yes 2 🔏 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be ê Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D37142 October 06, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman. M.D., 6001 Muncaster Mill Road, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 06, Physician/ 11:15am Robert Gruber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** #1614 Montgomery 4701 Willard Avenue, Chevy Chase 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days 572-42-3799 Director 1 **X** M 2 □ F 78 12/06/1933 Slovakia Usual Residence of Decedent er then "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 Yes 2 X No Chavy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter death with t al Hygiene. 1 other then "natural", or items 23a Funera 20815 U.S.A. 4701 Willard Avenue, #1614 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?,
1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Psychiatry Psychiatrist æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of t. Page 1 end 2 should be fill thent of Health and Mental rtant: If Item 27 is marked signry or other traumatic even Irene Preuss Henry Gruber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 4701 Willard Avenue, #1614, Chevy Chase, MD 20815 Carolyn Gruber - Spouse altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once, 1 ☐X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 10/09/2012 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each the. Immediate Cause (Final Acute Myocardial Infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation/Atrial Flutter Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician end burial-transit Exami Severe Ischemic Cardiomyopathy Hospital or Attending Physician: The law requires thet the deeth certificate be executed Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Lateral Sclerosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? After this certificate 1 Yes 2 No funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \begin{align\*} \begin{align\*} \text{Residence} & 6 \subseteq \text{Other} \text{Other} \( \text{Specify} \) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending s after death.
I Director: After significant significa 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be To the Hospital or Attel within 24 hours after des To the Funeral Director completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature un O (DC) October 08, 2012 MD11924

State Registrar

DHMH 17 Rev 06-2011

ack

1120 19th Street, NW, Washington, DC 20036

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.,

Steven Lerner,

31. Date filed (Month, Day, Year)

OCT 6 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death .<sup>Day</sup>2012 Physician/ October 7 9:25 A M Sheila P. Gradowski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Manor Care Bethesda If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Months 579-46-4736 Director 77 Yrs Jan. 2, 1935 Ohio Usual Residence of Decede ir then "neturel", or Items 23e or 28e-f show the Modest Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County death with the Maryland Director 1 ☐ Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 5706 Balsam Grove Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White 3 Uidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 end 2 should be filed Department of Health and Mentel Hy Importent: if Item 27 Is marked oth eny Injury or other treumetic event 90e8. 17. Father's Name (First, Middle, Last) Josephine McCarthy Frank McCue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5706 Balsam Grove Court, Rockville, Maryland 20852 Leonard S. Gradowski/Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of October 11, 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Bethesda-Chevy Chase, Inc Maryland 20814 Milha M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause en each line. Approximate Interval Between Onset and Death UNKNOWN Immediate Cause (Final Dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospitel or Attending Physicien: The lew requires thet the death certificate be executed use as the burial-transit sate has been signed by the ettending physician and page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day 4 Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Poor intake, Adult Failure to Thrive, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available 24a. Was an Hypertension prior to completion of cause of death? performed? Yes 2 K No 1 ☐ Yes 2 ☐ No After this certificate 24 hours after death.
• Funerel Director: After this certifics etely filled in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?
1 Yes 2 No Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 - Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 1 KI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Certifying Projection: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 8, 2012 www a D43121

Registrar

DHMH 17 Rev 06-2011

State

605 Main Street, Laurel, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Nurul A. Chowdhury, M.D.

31. Date filed (Month, Day, Year) QCT 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Norman Harold Horwitz 2012 8:40 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3807 Bradley Lane Chevy Chase Montgomery Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Director 043-30-4099 1**X**XM 2 □ F 87 May 4, 1925 Minnesota Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Chevy Chase 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3807 Bradley Lane 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ≦ 1XXYes 2 ☐ No If Yes, Give Maryland 21215-0036 hours after Il Hygiene. other than "natural", 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. Korea 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Health Care / Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Surgeon Medicine Be permit. Page 1 and 2 should re filed Department of Health and Mental Hy Important: If item 27 is nearked ott any liury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alec Horwitz Jean Himmelfarb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erica Horwitz / Daughter 6 School Lane, Scarsdale, NY Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory | Oct.8,2012 Beltsville, MD Signature of Funeral Service Licens Rapp Tuneral Facility Cremation Services M00382 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) lar Winson's Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) nding physiclan and use es the burial-transit or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use es the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 No Pregnant at time of death Day 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown been Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D10287 OCTOBER 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

**OCT 0 9** 

BRANDIS MARSH, M.D., 106 IRVING ST. NW, WASHINGTON D.C. 20011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25, per me, g933 11-20-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hester Month 08:05 M Harris October 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of-Maryland Medical Center University Baltimore . Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 217-22-4150 1 □ M 2**X** F 88 MARCH 12,1924 MD Usual Residence of Decedent or 28a-f shov with the Maryland 10a, State 10b. Count 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 1731 McCULLOH ST. 21217 **USA** death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 10 þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ▼ Widowed 4 □ Divorced Specify: Completed BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PRESSER 12 REGAL LAUNDRY Be 17. Father's Name (First, Middle, Last) unk. 18. Mother's Name (First, Middle, Maiden Surname) မ EDNA BROWN 19a. Informant's Name/Relationship (Type, Print) Bb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1731 MCCULLOH ST. BALTIMORE, MD 21217 LINDA HARRIS STANLEY/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 10/09/12 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC mes 9. 1701 LAURENS STREET, BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician/ Intraper disease or condition resulting in death) hemorrh Medical Due to (or as a consuluence of Examiner Sequentially list conditions, I any leading to in reclassicause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last CEPTIFIC YOUN APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) auDivision of Vital Records, P.O. Box 68760  $\mathcal L$ the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be use as t IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 🗌 No 1 Tes Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28590080 October 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene 201 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HYATLEWIS October Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Northwest HOSPITAL Randallstown Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year, 215-42-2256 Director 1 X M 2 □ F 73 01/28/1939 MD 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits BALTIMORE 1 Yes 2 No OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10115 LYONS MILL ROAD 21117 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 ☐ Never Married 2 🕅 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 🗆 Widowed 4 🗆 Divorced If Yes, Give Year or Dates Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) GENERAL CONTRACTOR CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL HYATT FLORENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 Is
any injury or other trau JACQUELINE HYATT/WIFE 10115 LYONS MILL ROAD, OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 10/07/2012 WOODLAWN, MD 21. Signature of Fune al Service Licensee 22. Narme and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final yocardial infarction Physician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transi resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be of thours after death.
 Funeral Director: After this certificate has been signed by the attending physicia Box 68760 ed by the attending p detached for use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, EGRD 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy 1 ☐ Yes 2 ☐ No Yes 2 - N 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No **Division of Vital** 26. Place of Death (Check only one) မ ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b. Signature and title of certifier D65843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abdollah Kafrouni, 5401 Old Court Road, Randallstown, MD 21133 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Edward Kyle Hall Oct. 2012 8:56A 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Edgemere 7227 Waldman Avenue Birthplace (State or Foreign Country) ear I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Months Davs Hours Min. 1 ★M 2 ☐ F 15,1940 Virginia 213-36-0627 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Tyes 2X No Edgemere Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7227 Waldman Avenue United States 21219 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel\_Industry 12 Years Year Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Duncan Lincoln Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 7227 Waldman Avenue Edgemere, Maryland Mrs. Hattie A. Hall (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Milltop Service Corp. 10/8/2012 Towson, Maryland 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility Fisher 21. Sign fure of Funeral Server ensee Ch.1. Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) discore vsale til Years Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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29a. Certifier

**Physician** 

Examiner

**Funeral** 

Director

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

J Hygiene. other than "

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Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-tran physician Physician/Medical the

24a. Was an

1X Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 □Could not be 3 Suicide

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

End stage Renal Disease

28c. Injury at Work? 1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

determined

29c. License number 0000

29d. Date signed (Month, Day, Year) 10 0

30. Name and ad address of person who completed cause of death (Item 23a) (Type, Print) Br Amor dem

State Registrar 31. Date filed (Month, Day, Yea, QCT 0 9 2012 Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM# I PERPHYS G932, 10/9/2012 WS
State of Maryland / Department of Health and Mental Hygiene 32264 Reg. No.20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jerry Harps Jr. Month **Physician** 12.50PM october 2012 /Medical 4b. City, Town, or Location of Death 4c. Courfty of Death 4a Facility Name (If not institution, give street and number) Examiner Baltimore Frederick Village Nursing Home Catonsville if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1√2 M 2□ F Months Yrs. Director 249-03-2577 30 93 SC Usual Residence of Decedent be filed within 72 hours aftar death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b County other traumatic event, the Medical Examiner must be nortified at Y□ Yes 2□ No Funeral Director Baltimore MD NA 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ U.S.A. items 23a 3010 Larue Square 21225 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 11. Marital Status Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 ☑ No Specify: Black Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th grade na 18. Mother's Name (First, Middle, Maiden Surname) parmit. Pegas 1 end 2 should be fill Department of Health end Mantal Hy important: If flem 27 la marked oths any Injury or other transmit 17. Father's Name (First, Middle, Last) Christanna Moody Jerry Harps Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3010 Larue Square, Baltimore, Md 21225 Sheila Wactor-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Denation 5 □ Other (Specify) 10/9/2012 Marion, SC Jackson-McGill 21. Signature of Funeral Service Licensee M22 Nathandradines of acity 4300 Wabash Ave, Baltimore, Md 21215 Part1 Enter the discase, or complications that caus shock or heart failule. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requiras thet tha daath cartificate be axecuted usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760, attanding physician for usa as the buria Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Aftar this cartificate has been signed by the a funeral diractor, page 2 should be datached t Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yea 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1.7 Yes 2K No this cartificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 dursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Aftart 1 Bivatural 5 Pending investigation Injury 1 □ Yes 2 □ No death. eral Director: A filled in by the fo 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🗹 crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

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nd title of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

MS

32. Registrar's Signature

29b. Signatur

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9c. License number

Frederick

29d. Date signed (Month, Day, Year)

20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #5, per fh, e938 4-2-13 sm
State of Maryland / Department of Health and Mental Hygiene for State Registrar 32265 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Lillian Ann Haase Z:40 a M 10 2012 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ROSEDALE FRANKLIN SQUARE MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) <sup>5.</sup> **218<sup>2</sup>26**1**3168** <del>220-20-1482</del> 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Hours Min. (Month, Day, Year) **Director** 1 □ M 2 □ F 82 9-1-1930 Maryland 28a-f shov aţ 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2X No Md. Balto. White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21162 <u>5801 Carrington Drive</u> USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten ا Examiner n Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal White 3 ₺ Widowed 4 □ Divorced Specify Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Winfield Venker Emily Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Haase III son 5801 Carrington Drive White Marsh, Md. 21162 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-8-2012 Middle River, Md. Holly Hill Signature of Funeral Service Lice see 22. Name and Address of Facility Schimunek Funeral Home, Inc. favie 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CONGESTIVE HEART disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performe death? certificate 2 No 1 Yes \_\_ Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 🔏 No 1 Yes ၉ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after occ...
To the Funeral Director. Afte 1 X Natural work? 5 Pending injury 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

DR. MUSTAFA FIDAHUSSEIN 31. Date filed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

30. Name and address

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Registrar

FRANKLIN

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SQUARE

29d. Date signed (Month, Day, Year)

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DR BALTIMORE

			For amend item 1	AMEND TTEM#23 State of Maryland 9a per fh g934	a per 1/Depa 12-1	PHYS G artment 8-12 v	932, 10/ of Health	9/201 and M	2 WS ental Hyg	giene	) I 2	32266	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Perveen Iqbal			Or Boatin		2. Date of Dea	th		3. Time of Death	
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	) Examin	er	4a. Facility Name (if not institution, give st 7117 Rolling Be	wn, or Locatior B <b>alti</b> m			4c. County	of Death					
	Funeral		5. Social Security Number 6. Sex		st birthday)	If Under 1 Months	Year If Under Days Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day)		9. Birthp	place (State or Foreign	
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	Maryl 28a-f	Director	MD NA	В	altin	nore						1 X Yes 2 ☐ No	
	th the 3a or tbe n		10e. Street and Number	_	_	10f. Zip 0				10g. Citizen of		try?	
	ath wi	Funeral	7117 Rolling Ben	d Road Apt  2. Was Decedent Ever in U.S.		Vas Deceder	21244		ify Yes or No-	PAKIS	e - Americ	an Indian	
9	or its	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No			nt of Hispanic O Cuban, Mexic		Rican, etc.)	Bla	ck, White, e	etc.	
8	urs eff tural",	ted	3 💢 Widowed 4 □ Divorced	If Yes, Give Year or Dates.			No Specif	'y: 		Specify	: AS	ian	
5	72 ho n "nat	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	lent's Usual ( kind of work ( O NOT use re	done during mo	st of workin	g	16b. Kind of B	usiness/Ind	dustry	
212	within giene. er tha		Elementary/Secondary (0-12)	College (1-4 or 5+)			ssocia	te		Wal	mart		
р	filed tal Hy od oth event		17. Father's Name (First, Middle, Last)				18. Mot	ther's Name	(First, Middle, I	Maiden Surnam	e)		
Ŋ	uld be d Men marke natic		Muhammad Iqbal	D: 0					Begum			0.7.0.4.4	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itams 23a or 28a-f show any Injury or other traumatic event, the Medical Evaminar must be notified at once.		19a. Informant's Name/Relationship <i>(Typ</i> Qura—Tul— <del>Aim</del> —Dau	ighter								ode) 21244 imore, Md	
re,	1 end of Hea of Hean fitem		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name	of er place)	D	ate	20c. Location	- City or To	wn, State	
Ë	Page 1 Iment of I tent: If it jury or o		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State Al-	Fird	ous M	emoria	1 10	/1/201	2 Fred	leric	k, Md	
Balt	permit. Departr Importe any inju	21. Signature of Funeral Service Licensee 22. Name and Address of Eacility.  March F/H West											
	48246	1	23a. Part 1. Enter the disease, or compli	cations that caused the death.	/ 143	300 W	<u>abash</u>	Ave,			Md 2	L1215 Approximate	
	Physician	ia 24	23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final	cause on each line. Care	iovas	cular	Disease	-6	,	,	1	Interval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque	ence of):		1-0111	XI G			-	aug	
	Examiner	Į.	Sequentially list conditions,	. —							_		
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence ot):						- 4		
	be executed slcian and burial-transi	Exa	that initiated events cresulting in death) Last	Due to (or as a conseque	ence of):								
09		dical											
Box 6876	ertifica ding p	/We	IF FEMALE:	3c. If yes, outcome of pregnan	cv					204.5	A 6 - 1 - 11 - 1		
ŏ	eath c etten	iciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3 [	Ectopic pre Other (spec					ate of delive onth	ery Day Year	
В	the diby the	by Physician/Med	g □ Unknown	9 🗆 Unknown					_				
Division of Vital Records, P.O.	es that igned be de	l by I	Part II. Other significant conditions con	tributing to death but not resu	lting in the u	inderlying ca	use given in Pa	rt I.				ne cause of death?	
rds	requir been s should	etec							24a. Was a			osy findings available	
ecc	≨ g ⊘	Completed							autop perfor	sy med?	prior to con death?	mpletion of cause of	
ᄪ	an: Th rtificat stor, pa	Be C	25. Was case referred to medical				26. Place of De	eath (Check		1 ☐ Yes 2 ☐ No			
Ę	Physical this ce al direc	10	TUSTES ZUINO	ospital: 1			*	Nursing Hor	ne 5 D Resid	ence 6 🗆 Oth	er (Specify)	)	
و ر	ding Pi th. After ti funera	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	1-53	c. Injury at work?	1	8d. Describe ho	ow injury occur	red		
Siol	Attenc r death ctor:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom	ne, farm, str	M eet, factory, o	1 ☐ Yes 2 l		28f. Location (Si	treet and Numb	er or Rural	Route Number,	
Ŏ.	rs after all Dire		4 - Hornicide determined	building, etc. (Specify)					City or Town				
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use es the	Medical	(Check 2 Medical Examine	cian: To the best of my knowle er: On the basis of examination Practitioner: To the best of my	and/or invest	tigation, in my	opinion, death	occurred at t	the time, date ar	nd place, and du	e to the cau	use(s) and manner stated.	
	Vithi To th	_	29b. Signature and title of certifier		-		icense number			29d. Date signe			
	, _		1045	e, MD		D	470	07		octoba	25 )	, 2012	
_	3/		30. Name and address of berson who co	7141 Secur	. In B	olval.	Ba	Him	ore w	10 2	124	4	
	Star Registra		31. Date filed (Mohth, Day, Year)  OCT 0 9 2012	32. Registrar's Signatu	bark				/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 2012 Physician/ Month GROTHY OHNSON 03 50 AM OCTOBER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAFOLIS Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours (Month, Day, Year) 327-42-6123 **Director** 1 M 2 X F February 18,1929 Illinois Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified Maryland Annapolis Anne Arundel 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral items 23a 2203 River Crescent Drive 21401 USA 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian an "natural", or ite Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XXVo Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Artist 4 Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname 2 Herman Lacy Florence Dunteman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Doria Rindos/Daughter 185 Doncaster Road, Arnold, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once, Kalas Crematory 4 Donation 5 Other (Specify) 10-6-12 Edgewater, Maryland 21. Signature of Tuneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Pat 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) OMPLICATIONS FRACTURE DAYS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury Due to for as a consectioner of that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as attending IF FEMALE: nse res, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Pregnant at time of death Month the 1 ☐ Yes 2 L 9 ☐ Unknown detached Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hospital or Attending Physician; The law requires FIBRILLATION Completed 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART 24b. Were autopsy findings available prior to completion of cause of has autopsy To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag perform death?
1 Yes 2 No PULMONARY CHRONIC OBSTRUCTIVE TIEASE 25. Was case referred to medical 26. Place of Death (Check only one) examina? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ☐ Natural ☐ Accident 5  $\square$  Pending OCT 2,2012 6500 PM 1 Yes 2 No FALL Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7205 Kives Cresuat D determined building, etc. (Specify) HOME Annapolis MD 21401 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nursa Practitioner: To the basis of my how long, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 5, 2012 D63054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJID CINA, MD 2001 medical Parkway Anacookis

State Registrar 31. Date filed (Month, Day, Year)
OCT 0 9 2012

32. Resintrar's Standing

			Amend #2,29d, pe	Type or Pri	nt in Black II	ndelible In	k. Ensure	All Copie	s Are Leç	jible.		
			1 - For State Registrar	State of M		artment of I <i>tificate of I</i>			giene Reg. No. 2 (	112 322	268	
	Physicia	an/	1. Decedent's Name (First, Middle, Las Bessie John	*				2. Date of De	ath <b>July 17</b>			
	Medi-		4a. Facility Name (if not institution, give			4b. City, Town, o	or Location of Death	1 2 0 4	4c. County	Year 222 of Death	<u>- 10</u> M	
-	Funeral		Northwes  5. Social Security Number 6. So	2x 7. Ao	pital e (In yrs. last birthday)	Randa If Under 1 Year	Il Stown	18. Date of Bird		Saltimore  9. Birthplace (State or		
	Director		219-14-0797 1  Usual Residence of Decedent	□ M 2 <b>X</b> F	94 Yrs.	Months Days	Hours Min.	1/1/0/1007	<sup>%</sup> /′†°917	Country) MD	roreign	
	yland f show ed at	tor	10a. State 10b. County MD Baltin	nore	10c. City, Town or Lo	cation In Oak				10d. Inside City		
	the Mar or 28a- e notifi	Dire	10e. Street and Number		Gwyn	10f. Zip Code			10g. Citizen of	1 ☐ Yes 2	2 🗓 No	
	hours after death with the Maryland natural", or items 23a or 28a-f sho lical Examiner must be notified at	Funeral Director	7007 Brompton				207			USA		
98	fter dea , or iter	b	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 X	No.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Blad	e - American Indian, ck, White, etc.		
-003	hours at natural" ical Exa	Completed	3 XWidowed 4 Divorced	If Yes, Give Year or Dates.		Yes 2X No			Specify			
1215	thin 72 nne. <b>than</b> "r <b>than</b> "r	omo	(Specify only highest gra	de completed) College (1-4 or 5	(Givo	kind of work done of NOT use retired)	during most of wor	king		usiness Industry maker		
nd 2	ifiled within 72 hours after tal Hygiene. ed other than "natural", o event, the Medical Exam	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,		2)		
Maryland 21215-0036	should be file and Mental is marked of raumatic eve	안	19a. Informant's Name/Relationship (T)	ne Print	Lion ve m	UNK				UNI	K	
	nd 2 sh lealth ar <b>m 27 is</b> h <b>er trau</b>		Crystal Greene		ent 7007	Brompt	and Number or Rui on Road	Gwynn	r, City or Town, S Oak M	21207		
nore	age 1 a ent of H nt: If ite y or oth		20a. Method of Disposition  1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of Dispo cemetery, cren Atlant	sition (Name of natory or other place ic Cren	n 7/1	Date 9 / 1 2		City or Town, State Burnie MD		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important if item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		21. Signature of Fulleral Service Licens		22	. Name and Addre	ss of Facility S1	mplici		m & Fun S		
	40 = 40	$\dashv$	23a. Part 1. Enter the disease, or comp	lications that caused	the death. Do not ente					Hanover I	MD	
	Physician/ Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	e cause on each line	rosclero			12	lisease	Interval Between		
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68760	eath certificate be attending physicia d for use as the bu	Physician/Medical		d								
Box 68	th certif ttending or use a	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 🗀 Fetal death 3 📃		>y		1	te of delivery		
). Bo	that the dea ned by the a detached f	hysic	1 ☐ Yes 2 ♣ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown		Other (specify)			Mo	nth Day Yea	ar	
s, P.O.	8 00	2	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the ui	nderlying cause giv	ven in Part I.			ibute to the cause of dear 3 Probably 4 Dun		
Records,	iw require is been si 2 should l	Completed			24a. Was a	an 24b.\	Vere autopsy findings ava	ailable				
Rec	ician: The law certificate has I rector, page 2 s		25 W					1 🗆 Yes	rmed?	orior to completion of caude leath? Yes 2 No	ise of	
of Vital	nysician: nis certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔣 No	lospital:	ent 2 KER/Outpatien	I Out-	ace of Death (Checer:		ence 6 \( \text{Othe}	er (Specify)		
n of	iding Ph th. After th funeral		27. Manner of Death  1   Matural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injur (Month, Day,		28c. Injury work M 1	y at		ne 5  Residence 6  Other (Specify)			
Division	l or Attendi after death. Director: A I in by the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, stre		res 2 🗆 No	28f. Location (Si		r or Rural Route Number,	;	
ā	To the Hospital or A within 24 hours after To the Funeral Direc completed filled in by	<u>a</u>	29a. Certifier 1 Z Certifying Physi	cian: To the best of r	ny knowledge, death o	ccured at the time,	date and place, ar	nd due to the cau	ise(s) and manne	r as stated.		
	the Horithin 24 the Fu		Uneck 2 - Medical Examin	ier: On the basis of ex	amination and/or investi	gation, in my opinic	on, death occurred a	t the time, date ar	nd place, and due ouuse(s) and ma	to the cause(s) and manne	er stated.	
	F > F 8		· Ql			29c. License	036919	1 '	29d. Date signed	(Month, Day, Year)		
	(4)		30. Name and address of person who co	Sm 1+6	ath (Item 23a) (Type, Pr	int)						
1	Stat	- 10	31. Date filed (Month, Day, Year)	32. Registrar	's Signature			=======				
	Registra	'	OCT 0 9 20	17 Beer	a A A	Called .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#8perFH, G932, 10/9/2012, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month 10.15 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Yur ing and ATONSVILL Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Joseph, Bay, October 1 - M 2 - F <sup>Y</sup>**1** 924 SC 242-32-3264 88 Yrs. Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 ▼ Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2407 ST. STEPHENS CT. APT. 1A 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 ☐ Yes 2 No Specify. Specify: "natural", 3X Widowed 4 □ Divorced BLACK Year or Dates If item 27 is marked other than "nature or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ift. Page 1 and 2 should be more atment of Health and Mental Hygiene.
The frem 27 is marked other than "n marin event, the Med (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **BCPS** CAFETERIA WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ISAAC JAMES: McCOY MATTIE SWINTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD LARRY McCOY/SON 218 KENWOOD AVE. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or GARRISON FOREST CEM. 10-10-2012 OWINGS MILLS, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Pag 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. at enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) ≟xaminer Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the burial-transit The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2/2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **N**o Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Sursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No Investigation 6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/5/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ack Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of I	Marylan		artment of			lental Hy	giene			00070	
_			Registrar	tificate of						Reg. No. 2 3 2 2 3 2 2 sath 3. Time of Death					
	Physicia	ın/	Decedent's Name (First, Middle								Month Day Year				
de.	Medic Examir		Thelma Louis  4a. Facility Name (if not institution		7)		4b. City, Town	or Locatio	n of Death	Oct.	3	3 2012   11:32A 4c. County of Death			
-	} LXGIIII		Prince George				Cheve					-		orge's	
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. la	ast birthday)	If Under 1 Year Months Day	ar If Und	ler 24 Hrs.	8. Date of Bir (Month, Da	th			ace (State or Foreign	
	Director		579-34-4791 Usual Residence of Decedent	1 □ M 2 🗓 F	8	4 Yrs.				June 1		1 856		ington, DC	
	and show	ا ة	10a. State 10b. County		10c. City	y, Town or Lo	cation			June .		720 I V		d. Inside City Limits	
	Maryla 8a-f	rect	MD Princ	ce George's	Cap	itol E	leights							1X Yes 2 □ No	
	a or 2	ĺΩ	10e. Street and Number	_			10f. Zip Code	•			10g. Cit	tizen of Wha	at Count	ry?	
	th witl ns 23 must	Funeral Director	1207 Addison				2074				US				
36	e filed within 72 hours after death with the Maryland tal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married 2 ☐ Mar</li> <li>3 ☑ Widowed 4 ☐ Divorced</li> </ul>	If Yes, Give	s? <b>X</b> □ No		Vas Decedent of f Yes, specify Cu ☐ Yes 2 【 I	ban, Mexic	can, Puerto I	cify Yes or No- Rican, etc.)		14. Race - Black, ' Specify:	White, et	tc.	
9	hours natura ical E	lete	15. Decede	nt's Education			lent's Usual Occ					ind of Busir			
21215-0036	in 72   e. <b>nan "r</b> Med	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1-4 o	or 5+)		kind of work don O NOT use retire		ost of worki	ng	100.11	TIG OF EGO!	1000) 11101	2011 9	
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m	Page nent c ant: If		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S			rerdale	natory or other p Crema		Oct.	9,2012	Riv	/erda]	Le, 1	Maryland	
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Pineral Service I	icense		22			-	B. Jenk oad Hya				Home, Inc. 20785	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caus	sed the death	n. Do not ente	er the mode of d	ying, such a	as cardiac o	r respiratory ar	rest,			Approximate Interval Between	
gari.	Ph, sician/		Immediate Cause (Final disease or condition							hmia				Onset and Death	
-	Medical Examiner		resulting in death)	Due to (or a	is a consequ	ience of):			7						
		er	Sequentially list conditions,	b. —	Company of the										
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dae to (or a	is a turisequ	ience on.									
	ate be executed hysician and the burial-transit	Exa	that initiated events resulting in death) Last	ience of):	nce of):						+				
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9289	tificat ng ph e as th	Mec	IF FEMALE:												
Вох	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcom  1  Live Birtl  4  Pregnan  9  Unknown	h 2 □ Feta tat time of d	Ideath 3	Ectopic pregna Other (specify)	incy				23d. Date o Month		y Day Year	
P.O.	that the		Part II. Other significant condition	ons contributing to death	but not resu	ulting in the u	nderlying cause	given in Pa	ırt I.	23e. Did t	obacco u	se contribu	ite to the	cause of death?	
	requires been sign should by	ed k								1 🗆	Yes 2	No 3	☐ Proba	ably 4 🗆 Unknown	
Sor	aw requi as been 2 shoul	Completed by								24a. Was		24b. Wer	e autops	sy findings available	
Re	ysician: The law r s certificate has b director, page 2 s	Corr								perfç	ormed?	dea			
tal	cian: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		-			eath (Check	only one)					
Ę	Physi this c	은 -	1 Yes 2 No 27. Manner of Death	1  Inpa		ER/Outpatier 28b. Time of	t 3 🗆 DOA			me 5 🗆 Resi			Specify)		
0 _	ding th. After fune	cate	1 Natural 5 Pendir 2 Accident Investi	ig (Month, E	Day, Year)	injury		ork? □ Yes 2		28d. Describe h	now injury	occurred			
Sio	or Attending after death. Director: After I in by the fune	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of I	njury - At ho etc. (Specify)		et, factory, offic					and Number or Rural Route Number,			
Division of Vital Records,	tal or A		4 El Hollinde detelli	City or Town, State)											
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director. After thi completely filled in by the funeral	Medical	(Check 2 Medical E	Physician: To the best ixaminer: On the basis of Nurse Practitioner: To	f examination	and/or invest	igation, in my op	nion, death	occurred at	the time, date a	and place,	, and due to	the caus	se(s) and manner stated.	
_	To the come		29b. Signature and title of certifier	10	7	11		nse number				te si <b>g</b> ned (N			
	)		1 aug	12/94	41	40	11	000	515	55	10	-4-	12		
			30. Name and address of person	who completed cause of	death (Item	23a) (Type, F	Al HASA	fal	1 /	SS hive	1 /	mn	311	185	
	Sta	e	31. Date filed (Month Day, Year)	010 32. Regis	trar's Sign	ure Ann	1900	iai		AIRYLKI	40	nn	CXU	,00	
	Registra		UCI 0 9 2	UIC sengua	Ja.	gal									

DHMH 17 Rev 06-201

Physician /Medical Examiner

signed by the attending physician and the detached for use as the burial-transit

page 2 should be

filled in by the funeral director,

this certificate has been

After

Hospital or Attending Physician:

death

after Dire

24 hours

within 2 To the

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Directo

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 obtain lighty or other traumatic event, the Market and Injury or other traumatic event, the Market and 1000.

Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

☐Yes 2☐No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EMPHYSEMA

24a. Was an

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Day

Year

autopsy performe 1 ☐Yes XX No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

1 🔲 Inpatient 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

and manner stated.

Hospital:

2 ☑ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, M.D. H. NGUYEN 31. Date filed (Month, Day, Year) 0CT 0 9 2012

6 Could not be

determined

GIOU OLD BRANCH AVE. TEMPLE HZUS, ND 20748 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20a-c, 22, per fh, g932 10-19-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ 6:00 PM M Jeffrey Johnson September Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 223-08-1163 Director 1 XM 2 □ F Yrs. Feb 5, 1960 52 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f shov 10a. State with the Maryland Examiner must be notified at Director 1 Yes 2X No Clinton MD Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20745 USA items 23a 9211 Stuart Lane permit. Page 1 and 2 should be filed within 72 hours after death v Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Madical Braminer nau once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black White etc. <u>ج</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: white If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) disabled unk none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Naill George Wilson Johnson Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1104 Newcomb Way Baltimore, MD Angela Johnson/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Beltsville,MD. in state Chesapeake Crematory 10-17-12 4 ☐ Donation 5 ☑ Other (Opecify) 22. Name and Address of Facility CAFA/Stephen D. Lohrman PA Signature Funeral Struce Licensee Director 212018717 Green Pastures Dr. Haltium Baltimore, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ule. Menoscient Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Securiting list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The lew requires that the death certificate be executed attending physician and burial-trar Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy To the Hospital or Attending Physician: The lew requires that the death of within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the atter completely filled in by the funeral director; page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at work? 1 🗌 Yes 2 🗆 No injury 1 Natural 2 Accident 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 D (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) icense number 29b. Signature and tifle of c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clinton,MD 20735 7503 Surrants Rd Sandra Banks Southern Md Hospital 31. Date filed (Month. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Reginald B. Johnson 05 615AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis multimedical Center Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 07 25 Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Hours Director 216-32-9472 1**X** M 2 □ F 35 77 ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21207 2806 Mohawk Ave Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married Y☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within 72 if Health and Mental Hygiene.
Item 27 is marked other than ' 12th grade College (1-4 or 5+) 2yrs Mass Transit Admin Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Bernice Humane Jeremiah Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2806 Mohawk Ave, Baltimore, Md 21207 LaVerne Johnson-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet.10/16/12 Owings Mills, Signature of Funeral Service Licensee March F/H West anya 4300 Wabash Ave, Baltimore, Md Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Freumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Dementia Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Anemia Completed Left lung pleural effusion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dysphagia page 2 s has autopsy performed? Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate b History of Renal Transplant Urinary Retention 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 No 1 Inpatient 2 I ER/Outpatient 3 I DOA pletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29d. Date signed (Month, Day, Year) 10/5/2012 A097104 Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle E. Kalendek, CANA

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 9 2012

DHMH 17 Rev 06-2011

Genesis Multimedical Center 7700 York Road Towson, MD 21204

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death bhason Physician/ Month Deniece 2015 PM Jane 1 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimor North WRST Hospital andallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 K Months Days Hours Min Yrs **Director** 33 09 07 212-96-6404 or 28a-f show notified at the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore MD NA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a may injury or other traumatic event, the Medical Examiner must be a Funeral U.S.A. 21244 8343 Mindale Circle Apt A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 2th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tammy Lynn Johns Terrance Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3317 Ripple Road, Baltimore, Md 21244 Terrance Johnson-Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, Donation 5 ☐ Other (Specify) 10/13/2012 Memorial Park Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Av Signature of Funeral Service Licenses Baltimore. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death disease Ph. sician. complication disease or condition Medical resulting in death) Due to (or a a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of: if any leading to knowed cause. Enter Underlying Examir Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 9 Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
9 Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown pinous Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 No Yes 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No ပ 1 Inpatient 2 NER/Outpatient 3 IDDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🕽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ within 2. only one) 29b. Signature and b 29c. License number 29d. Date signed (Month, Day, Year) Oct 04 2012 D0063918 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p Randallstown, Mi MITH 19 ( 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First\_Middle\_Last) 2. Date of Death Physician/ OCT. 04, 2012 CASTELLA KELLY 12:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 307-42-3549 1 🗆 M 2 🛛 F 71 APRIL 26,1941 INDIANA Usual Residence of Deci show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🌠 Yes 2 □ No MARYLAND PRINCE GEORGE'S LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be Funeral 23a 3102 82ND AVENUE 20785 UNITED STATES items ; Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Force Black, White, etc. or by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: 3 X Widowed 4 □ Divorced Completed BLACK Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ FEDERICK HUBBARD HELEN **GLENN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA KELLY / DAUGHTER 12604 PRINCES CHOICE DRIVE, BOWIE, MARYLAND 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 10/13/2012 RIVERDALE, MARYLAND 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD, HYATTSVILLE, MD 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician (ZESPIRKT ORY Medical Examiner NEMMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Further hoter Cause (Disease or injury that initiated events and Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 as IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descent at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months
1 Yes 2 No Day Month Year the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed embohsm Dulmonary 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy perform death? decubitus within 24 hours after death.

To the Funeral Director: After this certificate Sacral Yes 2 No Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 14 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type,

DHMH 17 Rev 06-2011

State

Registrar

William Boyce

0

9 2012

31. Date filed (Month, Day, Year)

PG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month September 2012 Robert S. King Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 528 S. Rogers Street Aberdeen 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Director 165-28-5185 1 🛛 M 2 🗆 F May 8, 1935 Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or items 23a o Funeral 21001 USA 528 S. Rogers Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian rmed Forces?

X Yes 2 \( \sum \) No Black, White, etc. ρ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: white Specify: **'**53-56 3 Widowed 4 Divorced Completed r than "natur the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 0 truck driver transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental I ျ Charles William King Dorothy May Schroeder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Lee King/spouse 528 S. Rogers Street Aberdeen, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final RECTAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): requires that the death certificate be executed as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery for 1 in the past 12 months?

1 Yes 2 No
9 Unknown Month be detached 9 Unknown P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 40 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 s autopsy performed? Yes 2 No After this certificate has funeral director, page 2: of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Division 'Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 00028475 PHYSICIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHICTP NIUMTPUMEN, SID UPPRINCHISAPIFAKIE PRIBELAIRMO 21014

2:00 AMM

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2X No

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 9 2012

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death bek 23 Year 12 Physician/ Month 0838 AM Jeannne Katzenberger EPTEM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAI HOSP mo Social Security No If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8 Date of Birth 9 Birtholace (State or Foreign Funeral Days Hours Min (Month, Day, Year) 196-24-0696 Director 1 □ M 2 🖾 F 1933 23, New Jersey Usual Residence of Decedent end Mariei Hygiene. Is merked other then "neture!", or Items 23e or 28e-f ehow reumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Maryland Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 773 W. Cross Street 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 O housewife own home Be permit. Page 1 and 2 should be filed. Department of Health and Mertel Hv. Important: If flem 27 is mextany injury or other. 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hughes/granddaughter Cross Street Baltimore. Beth 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signatur, or Funeral 8, rvice License, Licinal d. S. Wale, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Outer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician disease or condition resulting in death) a ACUTE MYCCARDIAL INFARCTION HOUR Medical Due to (or as a consequence of) Examiner ORDNARY ARTERY DISEAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the ettending physicien end completely filled in by the 'unerel director, page 2 should be deteched for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? σ. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CHRONIC OBSTRUCTIVE PLLMONARY DISEASE autopsy 1 ☐ Yes 2 ☐ No ANEMIA Yes 2 25. Was case referred to medical examiner? Vital 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death ð 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Siggature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Augeler ms 09/23/12 0 1) 22648 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerone Snyder, 31. Date filed (Month, Day, Year) OCT 0 9 2012 900 SOUTH CATON AVENUE BALTIMORE State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:15 Marquerite M. Kerrigan 2012 A.M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9 Birthplace (State or Foreign Funeral Days Hours August 15, 219-10-0453 Director 1 ☐ M 2XXF 87 Yrs Balt., Maryland 1925 permit, Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Evantiner must be retified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville 1 Ves 2K No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 21234 8820 Walther Blvd. of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XXNever Married 2 Married ş Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: 3 Widowed 4 Divorced Completed Year or Dates a.m. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Federal Elementary/Secondary (0-12) College (1-4 or 5+) Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kathleen McDonald Leo J. Kerrigan 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~21093sister-2300 Dulaney Valley Road F313 Timonium, Maryland Anne Kerrigan/ in-law Betty Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 6, nace of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Baltimore, Maryland OCTOBER 21. Signature of Funeral Service License Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) eral Director: After this certificate has been signed by the ettending physician and filled in by the funeral director, page 2 should be deteched for use as the burlel-transit Hospital or Attending Physician: The law requires that the death certificate be executed Lause (Disease or mjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical KERRIGAN IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown Dav 5 Other (specify) MARGUERITE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 X N 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE ဂ္ဂ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred after death. 1 X Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely only one) 29b. Signature and title of 29c. Lic 29d. Date signed (Month, Day, Year) 201 who completed cause of death (Item 23a) (Type, Print)

State

JONES,

JACKIE

CRNP

TIMONIUM, MD

21093

2300 DULANEY VALLEY RD.

32. Registrar's Stanature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedentis Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Seasons Hospice If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Country)
Maryland Days Hours Min 94 Director 1 □ M 2 🖾 F 215-01-6074 July 20, 1918 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mantel Hyglene.
Item 27 is marked other than "natural", or items 23s or 28a-1 show other trsumatic event, the Medical Exempter must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glen Arm Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21057 11630 Glen Arm Road Apt.# 158 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hairdresser Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Elizabeth Schafer George Otradovrc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Paga 1 and 2 sh mant of Haalth a sent: If Itsm 27 is 8641 Winands Road-Randallstown, Maryland 21057 Tammie Watson-granddaughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dapartmant of I Importent: If Its eny Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Evans himeral orapet Forest Hill, Maryland 4 Donation 5 Other (Specify) Cremation Ser Belair 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Services Evans Funeral Chapel and 8800 Harford Road-Parkvi L-ME endrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events Due to (or as a consequence of): ad by the attending physician and datachad for use as the burial-transit To the Hospital or Attending Physician: Tha law raquiras that tha death cartificata ba axecutad within 24 hours aftar death.

To the Funeral Diractor: Aftar this cartificata has baan signad by tha attanding physician and complataly fillad in by tha funaral diractor, pags 2 should ba datachad for usa as tha burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🗹 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner on he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Helen Mary Krysztofiak 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kaltimore Ballimore 926 Harford 8. Date of Birth 9. Birthplace (State or Foreign Year If Under 24 Hrs. Age (In yrs. last birthday) If Under **Funeral** (Month, Day, Country) Maryland Months Min 1 M 2 🔀 F 217-14-9511 89 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 🖁 No Baltimore Co. Examiner must be notified MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ö 23a Funeral 21224 United States 7501 Berkshire Road Kryszbfiak Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Specify: White 3 x Widowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) City Hospital Patient Aid 8 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Amy Bennett Charles Moudry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 7501 Berkshire Road Baltimore, Maryland 21224 Mary A. Anderson(Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ExBurial 2 Cremation 3 Removal from Dundalk, Maryland ared Ht. of Mary Cem. 10/11/2012 5 Other (Specify) 4 Donation 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Duto (or as a consequence of): dags disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it is mediate cause. Enter Underlying Cause (Disease or linjury that initiated events ner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy sate has been signed by the atter page 2 should be detached for u in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 1 ☐ Yes 2 ☐ No After this certificate ours after death. eral Director: After this certifics filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical To Be examiner Other: 4 Nursing Home 5 Residence 6 Wother (Specify) ASSISTED IN 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title R16229 ss of person who completed cause of Holder 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Mont 426 Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and nymber **Examiner** 9. Birthplace (State or Foreign Date of Birth (Month, Day) If Under 24 Hrs. **Funeral** Hours Days 86 18 Director 1 □ M 2 👿 F 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Completed by Funeral Director 1 Yes 2 No timore 10g. Citizen of What Country? 10e. Street and Number onas Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 Yes Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giverkind of work done during most of working life. IPO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) resser Be 18. Mother's Name (First, Middle, Maiden Surname, ျ or Town, State, Zip Code) 20a. Method of Disposition Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 10 4 ☐ Donation 5 ☐ Other (Specify) Sign aure of Funeral Service License 23a. Part 1. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner ATION APPROVED BY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) for use as the burial-trans and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death filled in by the funeral director, page 2 should be detached g Unknown signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 MNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗌 No Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending 10/4/2012 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) certifie 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>D</sup>2<sup>y</sup>012 OC T 21:06P M Virginia Irene Long Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Carroll Hospital Center Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 215-34-5963 76 Director 1 □ M 2 🖾 F 7-7-1936 MD Usual Residence of Decedent I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Funeral Director MD Carroll Westminster 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Timber Ridge Dr. No 314 21157 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced Specify:white Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Production Employee Book Publisher permit. Pege 1 end 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Franklin Gertrude Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti Jo Green-daughter 42 Liberty St., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Chremation 3 Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 10/8/12 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFletcher Funeral & Cremation 254 E. Main St., Westminster, MD 23a. P 11. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on weath line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir or Attending Physician: The law requires that the death certificete be executed ettending physicien and for use as the burlel-tren that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death signed by the end of the best of the detection of the det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate hes been s funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 1 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Tes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

P.O. Box 68760 Records, Division of Vital 24 hours after death. e Funerai Director: Aft eletely filled in by the fur within 24 hou To the Fune completely fi

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ð State Registrar

Medical

29a. Certifier

29b. Signature and fittle of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D20806

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 5, 2012 Dorothy S. Love 11:00 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 205-03-3645 Director 1 □ M 2 🔀 F Yrs. Nov. 7, 1914 New York Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other treumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5741 Edmondson Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married β Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Guidance Counselor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne) ည Squire Scofield Mabel B. Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Gilmartin Niece 126 Coopers Farm Road; Southhampton, New York 11968 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 10/8/2012 Pikesville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licenses Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville M01234 23a. Part 1. Enter the dis se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EUMONI disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). attending physicien and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 5 Other (specify) signed by the at Id be detached for 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DementiA Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.
To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be a should be the funeral director, page 2 should be a should be PERTENSION PONARY ARTORY DISEA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 No 1 Yes 2 1 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Gritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

OCT 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:05 PM October 201 Jarrett Spotswood Lickle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year)
Jul 01, Days Hours Year) 87 Maryland Director 1 M 2 □ F 1925 218-22-6985 Usual Residence of Decede ital Hygiene. ed other then "natural", or items 23a or 28e-f show event, the Macalex miner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🕅 No Baltimore Sparks 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral United States 21152 14221 Dove Creek Way Unit 103 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Decedent Ever III J.C. Armed Forces? 1 Payes 2 No If Yes, Give Year or Dates. W Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Self-Employed should be filed with and Mental Hygien 7 is marked other the 12 Entertainer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည t. Page 1 and 2 should be f trment of Health and Menta rtent: If Item 27 is marked njury or other treumatic en William F. Lickle Margaret Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14221 Dove Creek Way Unit 103 Sparks, MD 21152 Elizabeth Anne Lickle /Wife 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of importent: If it any injury or o Oct 06 Beltsville, Maryland 2012 Chesapeake Crematory 21. Signature of Funeral Service Licenses 22 Name and Address of Facility MO1583 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 1-50 PH 146 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the burial-tra Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed Yes 2 After this certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ANG 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М 2 Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 9

## For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 30, 2012 Physician/ Margaret Lord Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Days Hours Director 411-48-3472 1 M 2 X F Nov 21, 1933 78 orrant: If item 27 is marked other than "naturel", or items 23a or 28a-f show injury or other traumatic event, the Medical Eveniner must be notified at 10a. State 10b. County 10c. City, Town or Location Directo Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 400 Georgia Ct USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Mamed 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) healthcare registrar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ပ္ Sheridan Ernest Davis Margaret Virginia Collier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is any injury or other trau Janet Lord/daughter 206 Wyndhurst Avenue Baltimore, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatio Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No 9 Unknown Month signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٤ Records, Completed 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate funeral director, pag 2 -100 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: မ 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check з 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date/signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

4:15 AMM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Interval Between Onset and Death

Day

1 Yes 2 No

1 Yes 2 🔽 No

Virginia

white

Registrar DHMH 17 Rev 06-2011

State

ARATHI 31. Date filed (Month, Day, Year) NCHARL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

71040

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	aryland					and Mental I	Hygie	ne		00000
			State Registrar	**		Cer	tificate	of D	eath		Reg.	No. 20	12	0 2 2 0 0
- 15	Physicia		Decedent's Name (First, Middle, Las     Sam, Lagg	t)						2. Date o		Ž <sup>ay</sup> 201	ear	3. Time of Death 5:52 AM M
	Medic Examin		Sam Legg  4a. Facility Name (if not institution, give	street and number)			4b. City,	Town, or	Location o			4c. County of		3132 111
			Broadmead						ville			Balti	nore	
	Funeral Director		5. Social Security Number 6. Se 212-32-1746 1	7. Ag	e (In yrs. la	st birthday)	If Under Months	1 Year Days	If Under 2 Hours		Birth Day, Yea		9. Birthp Count	lace (State or Foreign ry)
			Usual Residence of Decedent	AWZDF	95	Yrs.				Nov 1	0, 1	.916		Jersey
	ryland -f sho ied at	ctor	10a. State 10b. County			, Town or Loc							1	0d. Inside City Limits  1  Yes 2 No
	he Ma or 28a s notif	Dire	MD Baltimo:  10e. Street and Number	re	Co	ckeysv	111e	Code			10a	. Citizen of Wh	at Coun	
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	13801 York Road	#255					21030	)		USA		.,
	death items ner m		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13. V	/as Deced Yes, spec	ent of His	spanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race -	America White, e	
36	al", or	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 24  If Yes, Give  Year or Dates.	No				Specify:			Specify:		
٦, ا	hours natur dical E	Completed	15. Decedent's Ec (Specify only highest gra	ducation		16a. Deced	ent's Usua	Occupa	ation	of working	16	b. Kind of Busi	ness/Inc	lustry
721	within 72 giene. er than " t, the Med	omo	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	life, DC	NOT use	retired)	_			_		
7.7. d 2	filed wil al Hygie d other event, th	Be	12 17. Father's Name (First, Middle, Last)	4		tea	cher	/adm		rator er's Name (First, Mic		educat len Surname)	ion	
S. S2Am, Maryland 21215-0036	d be fill dental irked tic ev	မ	Samuel Bradford	Legg						licia Bel		,		
7 Mary	should and N is ma auma	74	19a. Informant's Name/Relationship (Ty			1	_			r or Rural Route Nu				
	and 2 Health em 27 ther tu		Bruce M. Legg/son		20h BI	4586 lace of Dispos			Terra	ce Great		S, MD		
atBaltimore,	Page 1 nent of ant: If it ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specific	Removal from State		emetery, crem			e)	Date	200	s, Location - C	ity or io	wii, State
Balti	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Street State Anatomy Board 655 W. Baltimore Street										Street	
4	100	П	Raltimore MD 21201  23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line.  Approximate Interval Between											
0	Physician/	Ш	Immediate Cause (Final disease or condition	J	DEN	MER	ITI	A					ļ	Onset and Death
9	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):								-
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	ence of):								
-	uted nd ransit	cami	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
0	ate be executed hysician and the burial-transit	alE	resulting in death) Last	Due to (or as	a consequ	ence of):								
760	cate b physics the b	ledic		d									1	
ر 687	eath certificat attending ph I for use as th	an/N	23b. was decedent pregnant	23c. If yes, outcome 1  Live Birth			Ectopic r	reananc	v			23d. Date	of delive	ery
Sox Box	the att	Physician/Medical Examiner	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a 9 Unknown			Other (sp		,			Mont	h	Day Year
7 o.	requires that the de been signed by the should be detached	by Pt	Part II. Other significant conditions co	ontributing to death b	ut not resu	ulting in the u	nderlying	ause giv	en in Part I	. 23e. [	id tobac	co use contrib	ute to th	e cause of death?
ds,	quires en sig ould b	ted	Atriol	Y IBRI	110	nor	]	,		1	☐ Yes	2 <b>P</b> No 3	☐ Prob	ably 4 🗆 Unknown
)( ecord	law re has be ge 2 sh	Completed	Conglists	K H	CON	Tt	0/1	Ur	0	8	Vas an utopsy	pri	ere autop or to cor ath?	ssy fin <b>dings a</b> vailable npletion of cause of
- Re	ysician; The la s certificate he director, page		25. Was case referred to medical	Unsi	M			26 DI	on of Dogs	th (Check only one)	erformed res 2	No 1		2 🗌 No
Vital	ysicia is certi directi	To Be	evaminer?	Hospital:	ent 2 🗆	ER/Outpatien	t 3 🗆 D0	Othe	r /	rsing Home 5 🗆 I	Residence	e 6 🗆 Other	(Specify)	
\$ 5	ding Ph h. After thi funeral		27. Manne of Death 1	28a. Date of inju (Month, Da	rv I	28b. Time of injury		Bc. Injury work	at			njury occurred		
Sion	l or Attendi after death. Director: A I in by the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		ını - At ho	me form etre	M et facton		Yes 2 🗌		an /Ctrace	t and Number	or Purol	Route Number,
Division	al or A s after I Direct d in by		4 ☐ Homicide determined	building, etc			et, lactor)	, Onice			Town, Si		or nurar	noute Number,
П	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours and early careful and the the death of the Funerial affect death.  To the Funerial piector, there this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	ner: On the basis of e	xamination	and/or invest	gation, in	ny opinio	n, death oc	curred at the time, d	ate and p	lace, and due t	o the cau	se(s) and manner stated.
	To the within ?	Ž	only one) 3 Cortifying Nurs 29b. Signature and title of certifier	e Frectitioner Tott	e best of n	y Ricellodge		License		e end olene, end dis		Date signed (		
			* Barbar	( Car	ras	1//	<del>2</del>	D	382	392		10/2	10	2012
			30. Name and address of person who of BARBARA C	ARROL	LIK	11)	138	01	10	RK R	0,0	COCKI	-Vi	SVILLE, MI
9	Star Registra		31. Date filed (Month, Day, Year)  OCT 0 9 20	2 Registra	A Paragraphic	. fa	Ked		50		1		1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Langford Ramona Marie Oct. 2012 9:35P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 12 Lombardy Drive Dundalk Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min. Hours Director 213-52-3104 1 M 2 X F Dec. 17,1948 63 Maryland Pege 1 end 2 should be filed within 72 hours encours.
Iment of Heelth and Mentel Hygiene.
The marked other then "netural", or items 23a or 28e-1 show tent: If item 27 is marked other then "netural", or items 23a or 28e-1 show tent: If item 27 is marked other then "netural", or items 23a or 28e-1 show tent: If item 27 is marked other then "netural Examines must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Dunda1k 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 1718 Evergreen Drive United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ۾ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John J. Hook, Sr. Doris Airey 19a. Informant's Name/Relationship (Type, Print)(Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Harold James Langford, 1718 Evergreen Drive Dundalk, Maryland 21222 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pege 1 e Depertment of H Importent: If ite eny injury or ot 1X Burial 2 Cremation 3 Removal from Sta Mol1x Hill Mem. Gdns. 10/8/2012 4 ☐ Donayog 5 ☐ Other (Specify) Middle River, MD 21. Signature 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one capped on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition CPS Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated each. Due to for as a consequence of Examir or Attending Physicien: The lew requires that the death certificete be executed attending physicien end for use es the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death been signed by the s should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မှ 1 Tes t Residence 6 Other (Specify)

28d. Describe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 1 Natural 2 Accident 5 Pending hours after death. 1 ☐ Yes 2 ☐ No the Investigation **Director:** 3 Suícide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled In by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospitel within 24 hours a To the Funerel Completely filled Hospitei Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Ce 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nly one) re and title 29b 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar hor lec

ise of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#19b, perINF, G932, 10/8/2012, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2 Day Physician/ 201Ž<sup>ea</sup> 6:30 Kim Doan Le Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 586-16-0592 Director 1 🔯 M 2 🗆 F 83 May 14, 1929 Vietnam Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20886 United States 19118 Stedwick Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 ☐ Never Married 2 🕅 Married 5-0036 1 ☐ Yes 2 🕅 No Specify. Specify: 3 Divorced Completed Year or Dates Asian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2121 Prince George's Elementary/Secondary (0-12) College (1-4 or 5+) County Government 4 Social Worker Be Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bich Tran Bac Dinh Le 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1076 Methuen Court, Herndon, Virginia 20170-2353 Cuong Le / Son Department of Health Importent: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 7, cemetery, crematory or other place)
Montgomery
Crematorium, In 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bethesda, Maryland Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician an ( disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to influed at cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for se's noneequence of for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the ettending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 ☐ No eral Director; After this certificate has been signed by the effiled in by the uneral director, page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed' Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Marse Practitioner: To the best of my knowledge, death occur ed at the time, date and place 29b. Signature and title of certifier M10/02/2012 00 ess of person who completed cause of death (Item 23a) (Type, Print) 10/10 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0<sup>Da</sup> 09:30 2012 October Elaine Fraser Loomis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Landow House Assisted Living If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min Hours 026-30-9914 Director 1 □ M 2 🗴 F 10/13/1917 94 Minnesota Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Concord Middlesex MA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 01742 59 Martha's Point Road within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces 1 ☐ Yes 2 X No If Yes, Give by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: 3 X Widowed 4 Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Public School Child Psychologist traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental For them 27 is marked or rother traumatic eve ပ Lois MacKay Everett Fraser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11801 Gainsborough Road, Potomac, Maryland 20854 Joan Lewis - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🗆 Burial 2 💢 Cremation 3 🗔 Removal from State Lincoln Crematory 10/15/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature 🖠 Fu 22. Name and Address of Facility Simple Tribute Funeral & Cremation Cente 1040 Rockville Pike, Rockville, Maryland 20852 1241 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Phui ian Pulmonary Fibrosis Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury and -tran: that initiated events resulting in death) Last Due to (or as a consequence of): as the burialattending physician Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Day Year Pregnant at time of death signed by the Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed? Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate 2 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Assisted Hospital: Other: 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, October 08, 2012 D69568 ON: 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1799 E. Jefferson Street, Rockville, Maryland 20852 Damien Doyle.

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ October 2305 Debra Gail Levy Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 216-66-5086 1 D M 2 X F **Director** Vre July 07.1953 Maryland 59 er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10h Count Director 1 🗆 Yes 2 💢 No Silver Spring Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 20901 212 Thistle Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married δ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 721 h and Mental Hygiene. 7 is marked other than "n Geriatric Care College (1-4 or 5+) Elementary/Secondary (0-12) Management Social Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important If Item 27 is marked any injury or other traumatic any injury or other traumatic any injury or other traumatic and ည Florence Grunstein Charles Guggenheimer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 212 Thistle Court, Silver Spring, Maryland 20901 Edward Lawrence Levy - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 10/09/2012 Olney, Maryland Judean Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signatone of Funeral Service Licens 11800 New Hampshire Ave. Silver Spring. MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, any one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or o shock, or heart failure. List Immediate Cause (Final disease or condition Physician Neutronpenic Fever Medical resulting in death) Due to (or as a consequence of): Examiner Glioblastoma Multikorme Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami nding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending be detached for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b director, page 2 s autopsy performed 26. Place of Death (Check only one) director, 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at injury work? 1 \( \text{Yes} \) 2 \( \text{No} \) 5  $\square$  Pending 1 Natural 2 Accider Investigation Director: A id in by the f Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aff

To the Funeral Di

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D63579 October 08, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2012 OCT 09

Tayag,

M.D.

DHMH 17 Rev 06-2011.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3229 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2017 4. Lei's hear. 6-15 A M 22 Medical a. Facility Name (if not institution, give street and number)
102 North Crain Hwy Apt **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 860 Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Days Hours (Month, Day, Year) 212-34-3178 Country) Director 77 MD Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 Tes 2 No 10e. Street and Number Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 102 North Crain Hwy Apt 860 21061 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Steel Fabricator 12 Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Melvin H. Leishear Sr Ruth Hines rtraumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Carol E. Leishear Wife 102 North Crain Hwy Apt 860 Glen Burnie MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crem 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 9/29/12 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Arterio schooli Corne, Unalan Descuo typut curie disease or condition resulting in death) 40000 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami and -trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month the 9 Unknown Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dialetel Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Old cerestouriera tecident 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy page performed? Yes 2 No Pergheral Vercoion certificate Dilan To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Amesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Signature and title of certifie 29d. Date signed (Month, Day, Year) D19667 Vilace 09-28-2012 water 30. Name and address of poson who completed cause of death (Item 23a) (Type, Print) ciwantello Newmy Tribool # 508 Gen Bong Dayland 21061 7310 Pitchia ld

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

68760

Box

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Vital

Division of

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 9:59 P MRussell Lerch 2012 october . Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner University of Maryland Medical Center Baltimore 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days May 15, Year 1927 Country Maryland Hours 1**XX**M 2 □ F 85 216-20-0185 Director Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland Director 1 ☐ Yes 2xxxNo Maryland |Baltimore Arbutus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be Funeral United States 23a 21227 1034 Downton Road items death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Examiner Black, White, etc 5 1 Never Married 2 Married Yes Fres, Give 2 No ģ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Exami White 1 ☐ Yes 2 🛣 o Baltimore, Maryland 21215-0036 Specify Completed 3XXWidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Westinghouse Materials Handler Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Mollman မ Henry Lerch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Island Dr., Grand Prairie Texas 75054 Mary Emerson/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State Department o Important: If any injury or 4 Donation 5 Other (Specify) Oct.6.2012 Elkridge, Maryland Zion Cemetery 22. Name and Address of FacilityAMBROSE FUNERAL HOME, INC. Ture Funeral Service License Palyua MO1456 1328 Sulphur Spring Rd., Arbutus, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Intracranial Immediate Cause (Final hemorrhage Phy ician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hemorrhaa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be (24 hours after death. Funeral Director: After this certificate has been signed by the attending physicial Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant
9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? performed Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I DOA 1 🗌 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Division

State Registrar only one)

31. Date filed (Month

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.W. WANG 22 South Green 22 South Greene St.

3. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c, License number 727462 29d. Date signed (Month, Day, Year)

Baltimore, Maryland.

12-07446 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sean Melton, Sr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Reg. No 2. Date of Death Physician/ 3 Time of Death Month Day October 1, 2012 Medical Examiner 2359 hrs Sean Melton Sr. 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Maryland Months Days Hours 06/27/1969 Director 215-06-5731 1 M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Maryland Baltimore 1 X Yes 2 No s 23a or 28a-f show e notified at once, altimore, MD 21215-0036

mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Montal Higgiene.
portrant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ary or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 2811 Ouantico Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes 2 X No 1 Yes 2 X No specify: 3 Widowed Divorced If Yes, Give Year Specify: Black à 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Industry Cook 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernice Parson Robert Melton Jr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 Birch Drive Baltimore Maryland21207 Monica Melton/Sister 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Woodlawn Maryland 10-13-12 Woodlawn Cemetery 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore MD.21215 ulle 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Gunshot Wound of the Chest Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed /Medical UNPENDED AMENDED After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial -23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' ✓ Yes 2 No 2 No 1 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 PER/Outpatient 3 DOA 1 V Yes 28a, Date of Injury (Month, Day, Year) Oct 1, 2012 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject was shot Natural 2328 hrs 1 Yes 2 V No 5 Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2811 Quantico Avenue, Baltimore, MD determined (Specify) Single Family Home 4 🗸 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) OCT 0 9 2012

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

82. Registrar's Signature ORIGINAL O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

October 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death UCTUBOS Physician/ 05 2013 Medical cility Name (iftnot institution. Examiner give street and number. or Location of Death 4c. County of Death 8. Date of Birth Birthplace (State or Foreign Country) Age (In rs. last birthday) Funeral (Month, Day, Year) 218-41-9285 1 M 2 D F **Director** 18 05/31/1994 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No Davidsonville Anne Arundel Marvland 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 21035 items 23a Funeral 1037 Mt. Airy Road United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner Black, White, etc. 1 X Never Married 2 Married ō þ ☐ Yes 2 💢 No within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify "natural" Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Student Education Be 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Kelley 17. Father's Name (First, Middle, Last) and Mental His marked of Derril Mackin . traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat 1037 Mt. Airy Road, Davidsonville, MD 21035 Catherine Mackin/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/13/2012 Millersville, Maryland Baldwin U.M. Church Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fune 22. Name and Address of Facility George P. Kalas Funeral Home Service L 2973 Solomons Island Road, Edgewater, MD 21037 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Due to (or as a const uence of) disease or condition Medical resulting in death) **Examiner** Due to (or as a consequence of): uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Por in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 1 Inpatient 2 ER/Outpatient 3 DDA
28a. Date of injury
(Month, Day, Year) 28b. Time of injury
injury 28c. Other 2 🗌 No 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending after death. Director: Af 2 No filled in by the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Pactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state re and title of certifier 29d. Date signed (Month, Day, Year) -000 10/07/2012 of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	_	For State Registrar				tificate					Reg. No	- 0	12	32295	
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<i>y</i>		Frederick Villa				If I la via -		onsv		I			1timo		
Funeral Director		5. Social Security Number 6. Se 214-74-4016	ex 7. Ag □M2 <b>X</b> IF	Months Days Hou				If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)				
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should be filed within 72 hours after death with the Maryland and Mental Hyglene.  is marked other than "natural", or items 23a or 28a-f shoraumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Ty	/pe, Print)		19b. Mailir	ng Address	(Street a			al Route Number			ate, Zip Co	ode)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Cathy A. Plitt /	Daughter		5126	S. Ro	11i	ng Rd	., E	lalethoi	rpe,	Mary	land	21227	
Page 1 and 2 ment of Heatth ant: If item 27 iry or other to		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐	Removal from State	C	lace of Dispo emetery, cren	natory or oti	her place			Date		ocation - (			
it. Pag intmen intant: njuny		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licens	<i>(y)</i>	Met	ro Cre	emator	y Ir	nc. 1	0/08	3/2012	Ba1t	timor	e, M	aryland aryland Inc	
permit. Departi Import any inj		21. Signature of Funeral Service Licens	Elan	it Tay										aryland Inc d 21228	
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or			h. Do not ente	er the mode	of dying	g, such as	cardiac o	or respiratory ar	rrest,			Approximate Interval Between	
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certific nding use as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ncy							23d. Date	of deliver	rv	
death ne atte ed for	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Other (spe		У				Mont		Day Year	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical		ner: On the basis of e	examination	and/or invest	igation, in m	y opinio	n, death oc	curred at	the time, date a	and place,	, and due t	to the caus	se(s) and manner stated.	
To the To the Compl	Σ	only one) 3 ☐ Certifying Nurs  29b. Signature and title of certifier	e Flactitioner: 10 til	e best of fi	ny knowledge,	1		number	te ai iu pia	ace, and due to		te signed (	-		
1.1		Naymong Miller MD DA7683 10/8/12													
10,0		30. Name and address of person who c	completed cause of d				,	A4 A	***						
Stat	e	31. Date filed (Month, Day, Year)	32 Aegistic	ar's Signat	ure INSI	7 1411	.1	Mβ	21	117	·		-		
Registra		0CT 0 9 20	12 /2	41 1	2 600	May									

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		artment of Health and	Mental Hygie	ene				
			Registrar  1. Decedent's Name (First, Middle, Last)	Ce	rtificate of Death		Reg. No. 2012 32296				
Phys	sicia edic		Mildred Marshall			2. Date of Death	Day Year	3. Time of Death			
	min		4a. Facility Name (if not institution, give street and	,	4b. City, Town, or Location of Dea	4b. City, Town, or Location of Death 4c. County of Death					
			Union Memorial Hospita  5. Social Security Number 6. Sex		Baltimore n/a						
Fune Direc			219-22-1367	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min						
br wor	<b>=</b>	<u>_</u>	Usual Residence of Decedent  10a, State  10b, County	10c. City, Town or Lo	cation	raich /,		n Carolina  Od. Inside City Limits			
/lanylar 8a∽fs		Director	Maryland n/a	Baltimor				1 X Yes 2 □ No			
a or 2		Ö	10e. Street and Number	Daicinoi	10f. Zip Code	10g	. Citizen of What Count	ry?			
th with ms 23		Funeral	620 Wyanoke Avenue		21218		USA				
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trannatic event. the Medical Examiner must be notified at			_ Arme	ed Forces? Yes 2 🗹 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e				
003 ours aff turral",	di EXa	Completed by	Year	Yes 2 X No s, Give or Dates.	1 Yes 2 X No Specify:		Specify.black				
715-hc 172-hc an "na Medic	niegii.	mple	15. Decedent's Education (Specify only highest grade compl	(Give	dent's Usual Occupation kind of work done during most of wo IO NOT use retired)	orking 16	b. Kind of Business/Ind	ustry			
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Maryland 21215-0036 12 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	i and	0	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	den Surname)				
aryl nould b	in l		Albert Sanders  19a. Informant's Name/Relationship (Type, Print)	10b Maili	Florence and Address (Street and Number or Richard	ce Bowman	Trans Chata Zin Co	- d-)			
MC2sh d2sh saltha n27is		Î	Linda Bluford/daughte	1	Beechwood Drive (			· ·			
Baltimore, Dermit. Page 1 and Department of Hea mportant: If item any injury or other	5		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal	from State 20b. Place of Dispo	osition (Name of matory or other place)	Date 200	c. Location - City or Tov				
Itim it. Pag irtmen irtant:			4 Donation 5 Other (Specify)	Metro Cre	matory, Inc. 10/4	4/2012 Bai	ltimore,Mar	yland			
Department	once	ļ	21. Signature of Fund al Service Licensee Ste	phanie Custer 22	2. Name and Address of FacilityCre 99 Frederick Road	emation Soci	ciety of Ma	ryland, Inc.			
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not ent	er the mode of dying, such as cardia	or respiratory arrest,		Approximate Interval Between			
Ph sicia	THE WATER		Immediate Cause (Final disease or condition resulting in death)	Cardiova	scular Co.	112pse		Onset and Death			
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cuted and transit		Examiner	Cause (Disease or injury that initiated events c.								
ords, P.O. Box 68760 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		dical	resulting in death) Last Du	e to (or as a consequence of):							
8760 ificate b		Ned F	F FEMALE:								
th certific ttending or use as		ian/	23b. Was decedent pregnant 23c. If yes	, outcome of pregnancy Live Birth 2 🗌 Fetal death 3	Ectopic pregnancy		23d. Date of deliver				
be death of the atter	ŀ	Physician/Me	1 ☐ Yes 2 👿 No 4 🖳	Pregnant at time of death 5 [ Unknown	Other (specify)		Month D	ay Year			
rds, P.O. requires that the been signed by the		by PI	Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	cause of death?			
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e law r has b ge 2 st	.	Completed				24a. Was an autopsy performed	prior to com	y findings available pletion of cause of			
OT VITAL KECORDS,  g Physician: The law requires er this certificate has been signeral director, page 2 should be			25. Was case referred to medical		26. Place of Death (Che	1  Yes 2		□No			
VITC hysicia nis cer		일 일	examiner? 1 Yes 2 No Hospital:	1	_ Other:		e 6 Other (Specify)				
n of Jing P h. After tl funera	-		1 Natural 5 ☐ Pending	Date of injury 28b. Time of Month, Day, Year) injury	work?	28d. Describe how in	njury occurred				
DIVISION tal or Attendin s after death. al Director: Aft ed in by the fu		Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Rural R	oute Number			
LIN Ital or Ital or Ital or Ital or Ital or Ital Direction (led in led i			b determined	uilding, etc. (Specify)		City or Town, St		outo (varios),			
DIVISION OF VITAL  To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certific completely filled in by the funeral director,		ed	(Check 2   Medical Examiner: On the	e basis of examination and/or invest	occurred at the time, date and place, igation, in my opinion, death occurred	at the time, date and pla	ace, and due to the caus	e(s) and manner stated			
To the within To the compl		≥ ⊦	Ob Classition and Aller of a selfini		death occurred at the time, date and p 29c. License number	29d.	use(s) and manner as sta Date signed (Month, Da				
220	1		Signature at the of certifier Occil	MMR-	D005-886	0	OCT 3,	2012			
124	' '		30. Name and address of person who completed SHAWN DHHLL	cause of death (Item 23a) (Type, F	3 N. CALVETZI	- 57 SU	the BALTO	, m/21218			
Regis	State strai	r E	11. Date filed (Month, Pax Year) 9 2012	12. Fegistrar's Signature	all	_					

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			Decedent's Name (First, Middle,	Last)			timouto oi z		2. Date of De			3. Time of Death	
	Physicia Medic		William F	rancis	Miller				October	, Day	20/Z		
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and)	_		SINAI HOSPITA				BALTIN						
	Funeral		5. Social Security Number 217–18–8941	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of Birl	th y, Yea <i>r)</i>	9. Birt	hplace (State or Foreign untry)	
	Director		Usual Residence of Decedent	1 <b>X</b> ] M 2 □ F	89	Yrs.			2-14-	1923	MD		
	and show	ē	10a. State 10b. County		10c. Cit	y, Town or Lo						10d. Inside City Limits	
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	h the	a 0	10e. Street and Number				10f. Zip Code	21157		10g. Citizen of USA		untry?	
	e filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "naturel", or items 23a or 28e-f show event, the Medical Evanniner must be notified at.	Funeral Director	132 City Vie										
	or Iten	by Fu	<ul><li>11. Man'tal Status</li><li>1 ☐ Never Married 2 ☐ Marri</li></ul>	ice - Amei ack, White	rican Indian, e, etc.								
3	hours after naturel", or		3 XWidowed 4 Divorced	whi	te								
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7	iled within 72 Il Hygiene. : other than '	BeC	12	<u></u>		Pai	nter			Paint			
ğ	be filed antal Hy ked oth c event	일	17. Father's Name (First, Middle, La Wilbur E. Mi	•					Name (First, Middle, a Frick	Maiden Surnar	ne)		
Maryiand 21215-0036	should the and Me is mark		19a. Informant's Name/Relationshi			10b Mailir	on Address (Street :		r Rural Route Numbe	r City or Town	State 7ir	o Codal	
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ē,	1 end of Hea item		20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date	20c. Location	_		
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			23a. Par 1. Enter the disease, or shock, or heart failure. List or	complications that nly one cause on ea	caused the deat ach line.	h. Do not ente	er the mode of dyin	g, such as car	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death	
- , F	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ d	515						_	Onset and Death	
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		iner	Sequentially list conditions, if any, leading to immediate		(or as a consequ		001/01/74						
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3	physic the b			d.URO	EP515,	PREUM	MONIA, K	EDVIKE	TORY FAL	CUKE		15 DAYS	
Q/QQ	ding Jse as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy				234 [	ate of de	liven	
X Q Q	eeth o	icia	in the past 12 months?	4 🔲 Preg	Birth 2 Feta nant at time of o		☐ Ectopic pregnand ☐ Other (specify)	;y 			fonth	Day Year	
	the d by the tache	Physician/Medi	g 🗌 Unknown	g □ Unk									
Į.	s that igned be de		Part II. Other significant condition									the cause of death?	
S	equire een si oould	ted	CHRONIC LYMPHOC		•				1 🗆			robably 4 🗌 Unknown	
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or Vital	g Phy er this neral c	<u>اة</u>	27. Manner of Death	28a. Date		28b. Time o	f 28c. Injur	y at	ng Home 5 Resi			ify)	
5	endin sath. or: Aft he fur	fical	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investig	gation	th, Day, Year)	injury	M 1 🗆	? Yes 2 ☐ No					
Division	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined 28e. Place	of Injury - At ho ing, etc. (Specif)		eet, factory, office		28f. Location ( City or Tox		ber or Ru	ral Route Number,	
Ξ	pltel ours a erel D	edical (	29a. Certifier 1 Certifying	Physician: To the	peet of my know	lodge death	occurred at the time	date and nic	ace, and due to the c	ourse(s) and ma	nner oc ot	entod	
	To the Hospitel or Attending Physiclen: The law requires that the deeth certificete be executed within 24 hours after death.  To the Funeral Elector: After this certificate has been signed by the ettending physicien and To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medi	(Check 2 Medical E	xaminer: On the ba	sis of examinatio	n and/or inves	stigation, in my opinio	on, death occu	rred at the time, date a and place, and due to	and place, and c	lue to the	cause(s) and manner stated.	
	Vithi Com		29b. Signature and title of certifier	0 -	2/11	Ne	29c. License	number	105	29d. Date sign	ed (Mon)	h, Day, Year)	
	~\		- International	o a	l vic		WY DU	1221	100	16	/8/.	12	
	UX'		30. Name and address of person v	who completed cau	se of death (Item	23a) (Type, I	Print); KA	K 1	NY SIN	AI HOSE	ו גמדוי	OF BALTIMORE	
	Sta	te	31. Date filed (Month, Day, Year)	32.F	Registrar's Sign	ture	C'UT F			1.001		- Unclinake	
	Registr		OCT 0 9 2012	Burna 1	Registrar's Sign	arks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Michael Murphy John 8:15a 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carroll Sykesville 5933 Snowdens Run Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min Days Hours 400-44-0514 1 🛛 M 2 □ F 1935 KY Aug. 16 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Sykesville Carroll 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 5933 Snowdens Run Road 10g. Citizen of What Country? USA 21784 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 1953—1953—1958 |
If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) equestrian equine dentist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Sands Raymond Thomas Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) c/o 1339 Belcamp Rd., Suiet 216, Belcamp, MD 21017 Mrs. Betty J. Murphy (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 10-8-12 All County Cremation Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenşee Para Standy Herbert P O Box 195 Sykesville MD 21784

Ph\_sician/ Medical **Examiner** 

permit. Page 1.
Department of Important: If it any injury or or once.

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**Examiner** 

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Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Division of Vital Records, P.O. Box 68760

Judge Official of	1 .0. DOX 175 D	ykesville, ID 21704							
23a. Part 1. Enter the disease, or computed shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. ASCVI)	s cardiac or respiratory arrest,	Approximate Interval Between Onset and   eath						
	b. Due to (or as a consequence of):  c	Due to (or de a consequence or):							
	d								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions or	e of delivery th Day Year								
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Pa		bute to the cause of death?  3 □ Probably 4 □ hknown						
		autopsy properties of the performed?	lere autopsy findings available rior to completion of cause of eath?						
25. Was case referred to medical		eath (Check only one)							
1 Ves 2 No	Hospital:  1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Inpatient 2 Hospitality	Nursing Home 5 Residence 6 🗆 Other	r (Specify)						
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred  ☐ No	d						
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number City or Town, State)	r or Rural Route Number,						
(Check 2 Medical Exami	sician: To the best of my knowledge, death occurred at the time, date ar iner: On the basis of examination and/or investigation, in my opinion, death se Practitioner: To the best of my knowledge, death occurred at the time,	occurred at the time, date and place, and due	to the cause(s) and manner stated.						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2012 Year AUGUST Physician/ MATTHEWS 0:50 P TREDELL JR. Medical 4c. County of Death 4a. Facility Name (if not Institution, give street and number) 4b, City, Town, or Location of Death **Examiner** MONTGOMERY ALTHEA WOODLAND NURSING HOME SILVER SPRING If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Numbe **Funeral** (Month, Day, Yea APRIL 18 Months Hours SOUTH CAROLINA 1 ₺ M 2 □ F 250-26-7909 1926 86 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Martical Examples. 10a. State Director 1 Yes 2 No SILVER SPRING MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 1000 DALEVIEW DRIVE 20901 USA Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ NoA rmy Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2X Married ģ Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT LEGISLATE SPECIALIST Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ IRDELL MATTHEWS LILLIAN HALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18 RADIUM LANE PALM COAST. KATHERINE MATTHEWS/WIFE FLORDIA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State ARLINGTON CEMETERY 10/10/2012 ARLINGTON, VIRGINIA 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility Signature of Funeral Service Licensee Naphney N 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ATHEROSCLROTIC CARDIOVASCLAR DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** DIABETES MELLITUS Sequentially list conditions, Examine Due to for as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e, Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 24 No has 1 ☐ Yes 2 ☐ No this certificate 26. Place of Death (Check only one) the funeral director, 25. Was case referred to medical Certificate: To Be Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 2**X** No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 injury 5 Pending 1 Yes 2 No s after death. Investigation Accident 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a

To the Funeral I

completed filled Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie AUGUST 29, 2012 MI D60100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

OCT 0 9 2012 Registrar

31. Date filed (Month, Day, Year)

TAHMINA KHANAM AHMED MD 831 UNIVERSITY BLVD E SILVER SPRING, MARYLAND 20903 Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OCT. Physician/ 2012 LEONARD MALLORY 11:17 LEWIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) Min (Month, Day, Year) Hours 226-76-7604 Director 1 X M 2 L F 60 JUNE 16, 1952 VIRGINIA Usual Residence of Deced show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 X Yes 2 □ No MARYLAND PRINCE GEORGE'S LANDOVER 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 23a Funeral UNITED STATES 6710 HAWTHORNE STREET 20785 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Was Decedent Ever in U.S. Armed Forces?
1 🖾 Yes 2 □ No
If Yes, Give
Year or Dates1972-74 Black, White, etc. 9 1 Never Married 2 X Married þ Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK "natural" Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12TH POSTAL CLERK GOVERNMENT ulth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **JAMES** SHELTON Μ. MALLORY LOUISE Ε. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau PAMELA THOMAS / WIFE 6710 HAWTHORNE STREET, LANDOVER, MARYLAND 20785 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) VETERANS CEMETERY 10/19/2012 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ on eumonia disease or condition Medical resulting in death) (or as a consequenc of) Examiner iration Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine alvune attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed After this certificate has Yes completely filled in by the funeral director, or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident 3 Suicide Investigation 24 hours after deatl Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 only one) 29b. Signature and title of certified 29c. License number 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2012

2. Registrar's Sig

Please Type or Print in Black Indelible lak Finsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Year Physician/ 6:35 AM M October Medical Thomas Campbell Murray 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Timonium 332 Presway Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days (Month, Day, Year) Hours Min. Director 220-22-4835
Usual Residence of Decedent 1 🔀 M 2 🗆 F Jan 4, 1927 Maryland 85 or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland Medical Examiner must be notified at Director 1 🗆 Yes 2 😾 No MD Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 23a ( Funeral 21093 USA 332 Presway Road "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. Armed Forces?

1 XX es 2 H No
If Yes, Give
Year or Dates. Black White etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) steel company manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CAtherine Tighe ဂ္ OCTOBER John Franklin Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21093 Timonium, MD 332 Presway Road Julia C. Murray/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 X Donation 5 ☐ Other (Specify) 21. Singure of Emeral Service Linda, Director <sup>22</sup> Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or es a nonsequence of) the burial-transit and Due to (or as a consequence of) resulting in death) Last igned by the attending physiclan be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No certificate Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certificate: To After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 2 🗌 No within 24 hours after death.

To the Funeral Director, At completely filled in by the fu Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

only one) 29b. Signature and

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of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october Day 7 Albert Morris 2012 R. 07:08 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Yo Jan 12 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Days 218-36-4068 Hours <sup>(ear)</sup> 1942 Director 1 XM 2 □ F MD 70 Yrs. ir than "natural", or itema 23a or 28a-f show the Medical Examiner in ust be notified at 10b. County 10c. City, Town or Location ba filad within 72 hours aftar daath with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Scott Avenue 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 St Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mantal Hygiana. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Dept. of Army Pest Control Be 17. Father's Name (First, Middle, Last) permit. Paga 1 and 2 should ba filad Department of Health and Mantal Hy Important: If Ikem 27 is marked oth any lipiry or other traumatic even 2008. 18. Mother's Name (First, Middle, Maiden Surname) ည Morris John Α. Doris Ritter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Curreri-Morris (spouse) 109 Scott Avenue, Glen Burnie, MD 21060 Date 12 20b. Place of Disposition (Name of cemetery, crematory or other place)
MAryland Veterans Cent 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Crownsville, Maryland 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Like 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadaea, MD 21122 23a. Par 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ē Due to for as a consequence of Examl or Attending Physician: The law raquires that the death certificate be exacuted attanding physician and for use as tha burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day I ☐ Yes 2 ☐ No ata has bean signad by the a paga 2 should be datachad f the 9 Unknown 9 Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown swanyspar 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this cartificata has performed' rea 1 🗆 Yes 2 🗆 No Yes 2 N affar daath.

J Director: Aftar this cartifice id in by the funeral director, i 25. Was case ref examiner? Division of Vital Be to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No ၉ 1 Napatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident М Investigation To the Hoapital or Atter within 24 hours aftar da: To the Funeral Director complately fillad in by th 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. ecedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore 811 Kevin Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Year) 10-13-45 Hours Min. MD 214-40-8389 Director 1 M 2 □ F 66 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1XXYes 2 □ No MD NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 items 23a Funeral 21229 **USA** 811 Kevin Road 13. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 11. Marital Status Black, White, etc. African Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married à 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: American 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) City of Baltimore 12th Grade NA Office Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Clara McKinley В. Weems L. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda McKinley-Wife <u>811 Kevin Road Baltimore, Marvland 21229</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Garrison Forest VA 1 X Burial 2 Cremation 3 Removal from State 10-10-12 Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses Gilmor Street Baltimore, Maryland 21217 on omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, on shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ IVER disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last eral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

24 hours after death. Funeral Director: After this certificate has within 24 hou

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completely fil

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

30. Name and address of person who completed cause of death (Iter

31. Date filed (Month, Day, Year)

OCT 0 9 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20b perFH. G933, 1177/2012 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eunice Annie Morris 04 2012 6:33 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peartree Assisted Living Facility Pasadena Anne Arundel Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) Director 215-12-5377 1 🗆 M 2 😾 F 89 Maryland 03/06/1923 "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Co. Linthicum 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 321 Ardmore Road 21090 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 yrs. C & P Telephone Co. Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ James William Booker Pauline Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marie A. Leary / Daughter 8562 Main Avenue Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State <del>Unknown</del> 4 Donation 5 Other (Specify) Arlington Nat. Cem. 11/09/2012 Arlington, VA Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lip Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Ment LCar Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): signed by the attending physician and Id be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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3 Suicide Investigation 2 🗆 No s after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hounded to the second to the secon 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29c. License number who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 tate of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 40 AM Physician/ Day 10 240 Medical 4a. Facility Name (if not institution, give stree and number) lown, or Location of Death **Examiner** 4b. City, 4c. County of Death 220 alto If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Min. 5/22/1933 28-723 **Director** 1 M 2 - F  $C_{\ell}$ Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at death with the Maryland Director 1 Tes 2 No MOYA 10e Street and Number 5 10f. Zip Code 10g. Citizen of What Country? cjet Funeral or items 23a (t. 2121 U 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Š Maryland 21215-0036 1 ☐ Yes 2 🗗 No and Mental Hygiene, Is marked other than "natural", Specify: Completed Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Page 1 and 2 should be Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. roth. aptzzo Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-12-2012 21. Signature of Funeral Service Licensee Name and Address of Facility SEVUICE -une right ud 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause you neach line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 507 ure disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events anding physician and use as the burial-transit Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform after death.

Director: After this certificate! 1 Yes 2 No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 No ဍ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29671 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. EUJAW ST#305 BACTIMENEND 821 ANANDA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 21201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 4,2012 5:55 A M LEOLA ALVINE MARSH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTO. GILCHRIST HOSPICE TOWSON Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Days Min. (Month, Day, Year) Director 1 🗆 M 2**X** 🗆 F 215-24-9433 88 MARYLAND 9-23-1924 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director NOTTINGHAM MD BALTO. 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a **USA** 4008 KAHLSTON ROAD 21236 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOME HOMEMAKER traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nd Mental H ၉ ANNA M. BLAKELY t. Page 1 and 2 should be treent of Health and Men rtant: If item 27 Is marke CHARLES TEMPLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
828 ELLIOTT DRIVE BEL AIR, MD. 21015 19a. Informant's Name/Relationship (Type, Print) JANET M. STINCHCOMB DTR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MT. ZION UMC CEM. 10-9-2012 CHURCHVILE, MD. 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 9705 BELAIR ROAD NOTTINGHAM. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Fracher disease or condition month Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Finder Indenting Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregna in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 2 Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 D Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 130AM 1 Natural
2 Accident 5 Pending n 24 hours after death. e Funeral Director; Aft eletely filled in by the fur 1 ☐ Yes 2 No September 4,2012 Fall Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) home - bAThroom 4008 Medical KahlstonRoad 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie To the Hosp within 24 hou To the Funer completely fi (Check only one re and title of certifier 29d. Date signed (Month, Day, Year) 58303 OCTOBES 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V Charles ST TOUSON NOW N 31. Date filed (Month, Day, Year) State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mar				lental Hygi	ene 2012	2 32307	
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of De	<del>J</del> ain	2. Date of Death		3. Time of Death	
	Physicia	ın/	Richard Stanley Nacewicz				October	Dav Year	9:20 a M	
~	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death	OCLOBEL	4c. County of Dea		
ل	Xuiiiii		635 Camelot Drive		Bel Air			Harford		
	Funeral Director		5. Social Security Number  107-24-1064  Usual Residence of Decedent  6. Sex  1X M 2 G F  80	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Apr 26	ay, Year) Country)		
	show dat	ţ	10a. State 10b. County 1	0c. City, Town or Loc					10d. Inside City Limits	
	Mary 28a-f	Director	MD Carroll		rsburg	···			1  Yes 2 No	
	ith the	ral [	10e. Street and Number  1317 Placid Drive		10f. Zip Code 21784		10	ng. Citizen of What Co USA	ountry?	
	ath w ems 2 r πus	Funeral	11. Marital Status 12. Was Decedent Eve	r in U.S. 13. V	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe	cify Yes or No-	14. Race - Ame	erican Indian,	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		f Yes, specify Cuban, 1 ☐ Yes 2 🟋 No		Rican, etc.)	Black, Whit		
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pt 2	filed wall Hyg		17. Father's Name (First, Middle, Last)			18. Mother's Name				
ylar	Ild be Menta iarkec atic e	ပ္	Stanley Nacewicz			Genevie	ve Lani	ewski		
Mar	d 2 shou alth and 1 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Mr. Mark Nacewicz (son)	19b. Mailir 2300	ng Address (Street an Harvest F	arm Rd.,	Route Number, C Eldersb	City or Town, State, Ziurg, MD 21	ip Code) .784	
Baltimore,	Page 1 and the trent of Hermant: If item ury or other		20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Removal from State	20b. Place of Dispo	natory or other place,	1100		Sykesvi $11\epsilon$		
Itim	permit, Page 1 a Department of I Important: If ite any injury or ot		21 Signature of Funeral Service Licensee	22	y Cremati	011		ral Home 8		
Ba	permit. Departr Importa any inju		Daige Haught Herbers	r F	0.0. Box 1	95 Sykes	ville, M	D 21784	•	
)	hy i i n Medical Examiner	er	Sequentially list conditions, b.	STATIC consequence of):	PANCR				Approximate Interval Between Onset and Death	
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90	ate be	dica	d							
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy for the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live Birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	elivery Day Year	
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tal	ysician: s certific director,	Be	25. Was case referred to medical examiner?		26. Plac	ce of Death (Check		DAV	GHTER'S	
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o uc	Attending Ph er death. ector: After thi by the funeral	icate	1 XNatural 5 ☐ Pending (Month, Day, 1 2 ☐ AccidentInvestigation	Year) injury	work? M 1 □ Y	es 2 □ No				
Division	al or Attendin s after death. Il Director: Afi ed in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (	- At home, farm, str (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of exa 3 Certifying Nurse Practitioner: To the basis of examonal process.	mination and/or inves	stigation, in my opinior	n, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.	
	Voith Com		29b. Signature and title of certifier	<b>a</b>	29c. License	9 ,-11		9d. Date signed (Mon	0.0	
_	8		30. Name and address of person who completed cause of dea EW COLE ST AGNES	th (Item 23a) (Type, I	ATON AV	E BAL	TIMOR	10/08/2 E MD	21229	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's	3 Signature	W					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 5,2012 1902 P M HENRY C. NEWMAN JR. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE ROSEDALE BALTO. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min (Month, Day, Year) 38-48-4655 1 🕱 M 2 🗆 F 59 Yrs. NEW JERSEY JULY 6,1953 Usual Residence of Deced 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTO. PARKVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9916 NEARBROOK LANE 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married X Yes 2 No 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Year or Dates. 1973-1991 WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) EQUIPMENT ENGINEER WIRELESS INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY NEWMAN SR. ANNIE EBINGHAUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPOUSE JOANNE NEWMAN 9916 NEARBROOK LANE PARKVILLE, MD.21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town. State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARDENS OF FAITH 10-10-2012 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 21. Signature of Funeral Service License 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death disease or condition resulting in death) SC Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD.

**Examiner** 

**Funeral** 

Director

28a-f

items 23a or

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permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal

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Examiner must be notified at

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Funeral

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> sician and burial-transit Exami physician s the burial Physician/Medical attending pl ed by the a been signed be should be deta à Completed his certificate has bil director, page 2 st Be 욛 After this funeral Certificate: To the Hospital or Attendin within 24 hours after death.
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> To the Funeral Director: Af completely filled in by the fu

Physician: The law requires that the death certificate be executed

Box 68760

P.O.

Records,

of Vital

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Hospital or Attending

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that initiated events resulting in death) Last IE EEMALE 23b. Was decedent pregnant in the past 12 months? Yes 2 □ No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

2 🗌 No

5 ☐ Don

examiner?

27. Manner of Death

29a. Certifier

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death q | I Inknown

1 Inpatient 2 ER/Outpatient 3 I

28b. Time of

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number.

24a. Was an

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available pnor to completion of cause of death?
1 ☐ Yes 2☐No

Year

2	26. Place of Death (Check only one)													
DOA	Other: 4	☐ Nursing H	ome	5 Residence	6 ☐ Other (Specify)									
	Injury at work?	2 🗆 No	28d.	Describe how inj	ury occurred									

ccident	Investigation		М	
Suicide Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif)		ry,

28a. Date of injury (Month, Day, Year)

City or Town, State 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

office

(Check 2 Medical Examiner: On the basis of examination and/or investigationally one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death	n, in my opinion, death occurred at the time, date n occurred at the time, date and place, and due to	and place, and due to the cause(s) and manner state the cause(s) and manner as stated.
b. Signature and title o certifier	29c. License number	29d. Date signed (Month, Day, Year)

completed cause of death (Item (Ra) (Type, Print)

6+1 State

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Doretha Pringle-G	•	- For State	Stat	e of Maryl	and / [		tment of ificate of		and	Mental Hy	ygiene	Reg. N	20	)   ;	2 3	3230
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Medical Examine			Pringle-G								Month Septem				0907	hrs
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death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status	lylldill Ave	12. Was De	cedent Ev	er in U.S			of Hispa	anic Origin? ( Sp		No-	14. Race -	Americ	an Indian	ı, Black,
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Imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  taut: If item 271 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	8		ducation (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/In during most of working life. DO NOT use retired)									ndustry				
36 in 72 iical 1		Elementary/Seco		College (	1-4 or 5+)		Publica	tion Di	etm	ubation Sp	mialia	,+	Technool	or (		mont Sur
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical	Completed	17. Father's Name		ist)			TUDLICE	icitari Di		Mother's Name				.OL C	OVCLI	indic ove
215 se file rtal Hy ked o	8	Joseph Pri	ngle Sr.							Annie Mae						
ould be fi ould be fi d Mental s marked tic event,	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z											Zip Code	)			
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Baltimore, MD 212 permit Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marke injury or other fraunatic even		21 Agnature of Fu	in∺ral Service Lic	ensee			22. N	ame and Ad ) Tibood	dress o	of Facility [W]	lleton	WD	11133	1.OL	Earto	). W.
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Medical		failure. List on	ly one cause on											1		en Onset and Death
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	إ≧ٍ	if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated  Due to (or as a consequence of):  C.  Due to (or as a consequence of):														
ted J ansit	Examiner	events resulting in death) Last  Due to (or as a consequence of):  d.													_	
be executed sician and nurial - transit	gica	UNPENDED		AMENDED												
'60, zate be physic he bur	ĕŀ	F FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery														
ox 68760 eath certificate be attending physi for use as the bu	ig i	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day  4 Pregnant at time of death 5 Other (Specify)											ay	Year		
Box in death control the attented for us	Physician/Me	1 Yes 2 🗸	No 9 Unkno	- L			5 Oti	ner (Specify	<i>'</i> —							
O. E		Part II. Other signi	ificant condition	s contributing	to death b	ut not res	sulting in the u	nderlying ca	use giv	en in Part I.			co use contrib			
r, P.O.	ا <u>م</u>												No 3			
cords, P.O. law requires that the has been signed by 2 should be detach	<u></u>											topsy	pri	or to co		ings available of cause of
Reco	Completed										1 ✓ Ye	rformed s 2		ath? ✔ Yes	s :	2 No
Division of Vital Records, tal or Attending Physician: The law require as after death.  Al Director: After this certificate has been single of the function of	Be	25. Was case refer examiner?	red to medical	Hospital:						of Death (Check		_				
ing Physical Designation in the Physical Control of the Control of	9		2 No	28a. Date	Inpatient		R/Outpatient 28b. Time of I			at Work?			idence 6 🗸		Scene	
ision of Attending Ph r death. ector: After t by the funeral	<u></u>	1 V Natural	5 Pendin	(Mon	h, Day,Year		zob. Time of a	· ·		s 2 No	Lou. Docom	30 11011	inguity coodings			
or Atten after death Director:	<u> </u>	2 Accident	Investig	gation 28e Pla	ce of Injur	y - At hor	ne, farm, stree	et, factory, of	fice bui	ilding, etc.			et and Number	or Rur	al Route	Number, City
Divisior  Division  Sopital or Attend hours after death meral Director: y filled in by the	Certification:	3 Suicide 4 Homicide	6 Could r		)						or Towi	n, State)	)			
		29a. Certifier 1	THE STREET	sician: To the be	est of my k	nowledge	e, death occur d/or investigat	red at the tir	ne, date	e and place, and death occurred a	due to the c	ause(s) ate and	and manner a	is state	d. e cause(s	)
To Youth Com	Medical	29b. Signature and		and manner	stated.	_		29c. L	icense	number		29	d. Date signed	d (Mon	th, Day, Y	'ear)
			hing h	٥ , >	_			O.C.M.E. September 26, 2012								
2	ŀ	30. Name and addr		ho completed car Medical Exa				e Street	Baltir	more. MD 21	223		-			
Sta	te	31. Date filed (Mon			Registrar's					,						
Registr		00	T 0 9 20	2	W/-	A.	park									
DHMH 17 Rev 1/200	01	Ub	10350	The poor			ORIGINA	L					OCME			

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death Sept . Decedent's Name (First, Middle, Last) PROFFIT 5.17AM Physician/ OWEN 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENERAL (tOWARD) HOWARD HOSPIJAL COLUMBIA If Under 1 Year If Under 24 Hrs. 8. Date of Birth *(Month, Day, Ye*July 4, 1 Birthplace (State or Foreign Country) . Age (In vrs. last birthday **Funeral** Days Hours Min. 1 M 2 D F Months 578-07-6885 95 **Director** 191 Mary Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2√ No Howard Columbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6336 Cedar Lane #305 21044 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give Specify: white Completed 3 X Widowed 4 □ Divorced 41-45 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) civil service supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby Elizabeth Harris Donald Alfred Proffitt  $\begin{array}{lll} \mbox{Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)} \\ \mbox{Sandston Ct Laure1, MI)} & 20708 \end{array}$ 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing 13207 Diane Greene/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🏋 Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Sign up a Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Grdwarcular Direasi Altero relevolic Pnysician/ disease or condition resulting in death) Medical Examiner babl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examin ending physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) сотрете filled in by the funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 옏 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifie D30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back River mack load 258x Maryland

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June June 2012 20 6:10A M Willard Robert Price Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll The Dove House Westminister Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 218-18-0743 **Director** 1 🕱 M 2 🗆 F Jan. 24,1925 MD 87 Usual Residence of Decedent 28a-f show ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 □ No MD Carroll Westminister 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1234 Washington Road 21157 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married XYes 2 No þ Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working h and Mental Hygiene.
7 is marked other than "r traumatic event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Insurance Agent Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည artment of Health and Ment ortant: If item 27 is marke injury or other traumatic Earl Price Anna Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Woodside Dr., Westminister, MD 21157 Paul Price/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☑ Donation 5 ☐ Other (Specify) Univ.Med Sch 6/20/2012 Washington, DC 22. Name and Address of Facility Austin Royster Funeral Home Howard 21. Sign the Funeral Service Lice 0 3821 14th Street NW, Washington, 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 1057 disease or condition Medical resulting in death) Due to (or equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (o burial-transit 6 Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of attending physician I for use as the buris Ob Stenchaz Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Withnown Completed 24b. Were autopsy findings available prior to completion of cause of leath? 24a. Was an autopsy performed 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 100# 1 🗌 Yes 2 4 OVE မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of HOUSE Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) -0054218

State

31. Date filed (Month, Day, Year) Registrar

Kanery

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Rawan B. Kanen, 349

Males Im drive

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar	State	of Ma	-		ment of F licate of I	lealth and Death	Mental Hy	giene Reg. No. 🤈 (	112	32312
Physicia	ın	1. Decedent's Name (First, Middle Anne Lee Parrott	,,						2. Date of De Month		Year	3. Time of Death  12:30 A M
/Medic		4a. Facility Name (If not institution		number)		41:	. City, Town, or	Location of Deat		4c. County	of Death	12.30 A
		Genesisi Healthc		7 4 7 9	(In use loot high	h dout) If	Severna Under 1 Year	Park If Under 24 Hrs	0 Date of Pi		Arunde	
Funeral Director		5. Social Security Number 401.12.6201	6. Sex 1 □ M 2 <b>XX</b>		(In yrs. last birtl <b>95</b>		onths Days	Hours Min.		ay, Year) 1917	9. Birthp Coun	lace (State or Foreign try)
D		Usual Residence of Decedent			40. Oh. T	!					14	Od Incide City Limite
G Z IZ IS-UU30 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Exercities must be incitified at	ō	10a. State 10b. County			10c. City, Town		on				1	0d. Inside City Limits 1 ☐ Yes XX No
the N	Director	MD Anne A  10e. Street and Number	rundel		Severna		Of. Zip Code			10g. Citizen of	What Coun	
h with	a D	310 Genesis Way					2114	16		USA	A	
ems ?	Funeral	11. Marital Status	12. Was De	ecedent Ev Forces?	ver in U.S.	13. Was	Decedent of H	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	)- 14. Rad	ce - Americ	
s afte	by Fi	1 Never Married 2 Mar	I IT YES		0		Yes XX No	Specify:	,	Specif		
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yland build be file Mental H arked oth attic even	Be	17. Father's Name (First, Middle, <b>Able Lee</b>	Last)					Anne	me (FIFST, MIDDIE	, Maiden Surnan	ne)	
L COFF	ဍ	19a. Informant's Name/Relations	ship (Type. Print)		19b.	Mailing A	ddress (Street	and Number or R	ural Route Numb	per, City or Town	, State, Zip	Code)
and 2 sl ealth an m 27 is r her traur		Wayne Parrott	Son		2	2335 A	dam David	Way, Mari	riottsvill	e, MD 2110	04	
ore ges 1 g t of He if Item or oth		20a. Method of Disposition 1 □ Burial 2 <b>X</b> Cremation	3 □ Removal fro	m State	20b. Place of cemeters	Disposition y, cremato	on (Name of ory or other place	ce)	Date	20c. Location	- City or To	wn, State
timo		4 Donation 5 Dother (5	Specify)	III State	Bayview	_			5, 2012	Baltimor	e, MD	
permit. Departm Importa any Inju		21. Signapled Europh Service  K. Gregory Fi		401148		F		ss of Facility 'al Home, F Hwy S., Gl		, MD 2106	1	
- Physician		23a. Part 1. Enter the dis se, c shock, or heart failure. List Immediate Cause (Final	complications that t only one cause or	t caused to each line	the death. Do n	ot enter t	ne mode of dyir	ng, such as cardia	c or respiratory	arrest,		Approximate interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due t	to (or as a	consequence o	of):						
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ath certi	Į.	IF FEMALE: 23b. Was decedent pregnant			of pregnancy 2  Fetal death	ه ۱۲ د	ctopic pregnanc			23d. Da	ate of delive	ery
the deat	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 □ Pr		time of death		ther (specify) _	·y		M	onth	Day Year
S, R, R	by Ph	Part II. Other significant conditi	ions contributing to	death bu	t not resulting in	the unde	rlying cause giv	en in Part I.				ne cause of death?
cords, v requires the been signer should be a		a. He	COPB						1 🗆	Yes 2 □ No	3 ☐ Prob	pably 4 Groknown
The lay te has age 2	Completed								24a. Was auto perf	opsy ormed?	prior to co death?	psy findings available mpletion of cause of
VITAI	0	25. Was case referred to medica	al					26. Place of De	1 L Yes ath (Check only	2 🖳 No one)	1 □ Yes	2 LINO
OT VITA Physician: r this certific	To B	examiner? 1 ☐ Yes 2 ☑ No			nt 2 ER/Out	tpatient		4 La Nursing	Home 5□ Res	sidence 6 □Ot	her (Specit	(y)
on conding Pading Path.  After 1  funers	ertification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident invest	/8.4	ite of Injur Ionth, Day	y ( <i>Year</i> ) 28b. T	Time of njury	28c. Injur Wor M 1 🗆	ryat k?  Yes 2 ∐ No	28d. Describe	how injury occur	rred	
UNISION I or Attending after death. Director: After	tifica	3 Suicide 6 Could 4 Homicide deterr	minod Zee. Pla	ace of Inju	ry - At home, far . <i>(Specify)</i>	rm, street	factory, office		28f. Location	(Street and Num.	ber or Rura	I Route Number,
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical		ing Physician: To I Examiner: On the and m		examination an							
vithii To th	M	29b. Signature and title of certifie	er Man				29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)
		june	1010			_	Dur.	15019		10/5	1/2	
3		30. Name and address of person War War War War War 31. Date filed (Month, Day, Year	on who completed co	ause of de	8601 V	Type, Prin	rales	Hevy,	fuit	e 204, 1	hull	ersuite
Sta Registra	~	31. Date filed (Month, Day, Year, OCT 0 9 2012	Server 32	. Registra	r's Signature	1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death October Day 06 2012 Physician/ 11:37 pM Samuel Winters Patterson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) 210121225 Director 1 MM 2 - F Sept 10,1925 Penralivania th and Mental Hygjene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No HOLLIDAYS 3VEG BLAIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1518 WEST LOOP RD 16648 LLSA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
1f Yes, Give 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 □ Divorced Specify: WITI Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) INDUSTRIAL FACTORY WORKER t. Page 1 and 2 should be filed w trment of Health and Mental Hygi rtant: If item 27 is marked othe ijury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည PATTERSON D ELEANOR BURKHEIMER SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8140 CLAIBORNE DR FREDDUCK MD 21702 DUNNA KAY ITAMMEL/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of H Important: If ite any Injury or ot once. Method of Dispusition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) BLAIR MOMORIAL PARK Oct 11,2012 ALTOON A PA 22. Name and Address of Facility ARY - LOUINS Signature of Funeral Service Licensee eleste 21701 110 WEST SOUTH ST FREDORICK MD dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, we cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List only Approximate Interval Between Ohset and Death Immediate Cause (Final Priysician/ Se PSIS COUNT disease or condition resulting in death) Medical Due to (or as a consequence of): <sup>∕</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or right y that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ sate has been signed by the atterpage 2 should be detached for in the past 12 months? Day Month 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 D No Other: မ 1 Tyes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending iniury 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, Year) olen MD51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21704 rella 32. Registra 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH.G932.10/18/2012.WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ October 2012 9:05 Рм Phizacklea Dale Spencer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville Summit Park Health & Rehab. If Under 1 Year I If Under 24 Hrs. Social Security Number 163-30-3445 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Director 1 X M 2 □ F 74 May 25, 1938 Pennsylvania Usual Residence of Decedent ortent: If item 27 is marked other then "neturel", or items 23a or 28e-f show injury or other treumatic event, the Medical Exercines must be notified at Pege 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mentel Hygiene. snt: If item 27 Is marked other then "neturel", or items 23a or 28e-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? Funeral 21228 1502 Frederick Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 V Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 ☒ Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harrison Phizacklea Ruth Naomi Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Phizacklea Brother 21229 Kensington Road Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State Richland Cemetery 10-13-2012 | Johnstown, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Sign tun, of Foneral Se 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): ate has been signed by the attending physician and pege 2 should be detached for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funerel Director: After this certificate has I completely filled in by the funeral director, pege 2 s 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ရု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospitel or within 24 hours at To the Funerel D Medical ( 1 Certifying Physician: To the best of any knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certif 8350 WILLERS AVE#SOT BALT. cause of death (Item 23a) (Type, Print) Name and address of person who come W GOWIAGO 31. Date filed (Month, Day, Year) State Registrar

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene														
		_	For State		State of	of Marylar			ent of F ete of D		and M	1ental Hy		20	12	32315
			Registrar  1. Decedent's Name	e (First, Middle,	Last)		UEI	lllica	ite oi L	<i>Jeann</i>		2. Date of De			l ha	3. Time of Death
	Physicia Medic					y J. Pe	rry					Octobe	er 03	<sup>3</sup> , 20	Year 12	2134 м
	Examin	er	4a. Facility Name (if		give street and num 1033 Hosp	-		4b. Cit	**	r Location o CVET S		1a	40	c. County		tgomery
	Funeral		5. Social Security N	lumber	6. Sex	7. Age (In yrs.	last birthday)	If Und	der 1 Year	If Under 2	<u> </u>	8. Date of Bi	rth av, Year)	Birthplace (State or Foreign		
	Director		579-50- Usual Residence		1 □ M 2 🗖 F	75	5 Yrs.					April	03,1	937		hington, DC
	he Maryland or 28a-f show	cto	10a. State	10b. County		10c. Cit	ty, Town or La	cation		- 10				10d. Inside City Limits		
		Dire	Maryland 10e. Street and Nur	Mond nber	tgomery			10f. 2	Zip Code	Silve	r Sp	oring	10g. C	itizen of W	/hat Cour	1 ☐ Yes 2 🛣 No
	with	Funeral Director	14604	Orange	ewood Str					2090					u.s.	.A.
ယ	72 hours after death "netural", or itams	by Fu	11. Marital Status 1 ☐ Never Marr	nied 2 🗆 Mami	Armed Fo	cedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (S  If Yes, specify Cuban, Mexican, Puer						cify Yes or No Rican, etc.)			- Americ k, White,	ean Indian, etc.
903	rurs aft tural", al Exa	ted	3 🗆 Widowed		If Yes, Giv Year or D	ve				Specify:				Specify:		Black
215-	172 ho  an "ne Medio	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)										16b. F	Kind of Bu	siness/Ind	dustry
212	d within lygiena har th	Be Co	12		1	-4 or 5+)	·	Car	togra	ipher				Fed	eral	Government
land	should be filad withingend Mantel Hygiens Is markad othar the	2 2	17. Father's Name (		est) Leonard K	i.dd				18. Mothe	r's Name	e (First, Middle Ha		Sumame,		
Maryland 21215-0036	should end M Is mar		19a. Informant's Na	ame/Relationshi	ip (Type, Print)							l Route Numb	er, City o	r Town, St	ate, Zip (	
	1 end 2 s of Health item 27 othar tre															
E O	Paga 1 nent of int: If ii		20a. Method of Disposition    20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - (20c.											•		
Baltimore,	permit. Paga 1 and 2 should be filad within Department of Health end Mantel Hygiens Important: If item 27 Is markad othar th any Injury or othar treumetic avant, the once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home,												Home, Inc.	
	20240	1 New Hampshire Ave., Siever Spring, Mi												, MU 20904 Approximate		
	Physician		shock, or hear Immediate Cause ( disease or condition	ırt failure. List or (Final	nly one cause on ea	ach line.										Interval Between Onset and Death
9	→ Medical Examiner		resulting in death)	-		ght MCA (or as a conseq				, , , , , , , , , , , , , , , , , , ,	-carer	20,10000	Cic		1	
		iner	Sequentially list co if any, leading to in	nmediate		ute Ren (or as a conseq		eure							+	
	requiras that the death certificete be axecuted been signed by tha ettending physician and should be datachad for use as the burial-trensit	Examiner	cause, Enter Under Cause (Disease or that initiated events resulting in death)	injury		ronic R		tory	Fail	'ure					_	
0	be axe /sician e burial	= 1	resulting in death) i	Last	d.	(or as a conseq	derice oij.									
Box 68760	Physician: The law requiras that the death certificete be this certificate hes been signed by tha ettending physic rai director, page 2 should be datachad for use as the b	Physician/Medica	IF FEMALE:													
ox 6	eath ce ettend d for us	ician	23b. Was decedent in the past 12 1 \( \subseteq \text{Yes} \) 2	months?	1 Live	tcome of pregna Birth 2  Feta gnant at time of	al death 3	Ectopi Other		су				23d. Date Mor		ery Day Year
P.O. B	t the de by tha	Phys	9 Unknown		9 🗆 Unki	-101 11										
S, P.	iras tha signed d be da	g P	Part II. Other signif	icant condition	is contributing to d	eath but not res	sulting in the i	underlyin	g cause giv	ven in Part I						ne cause of death?
ord	w requisited special s	Completed by										24a. Was	an	24b. W	/ere autor	psy findings available
Rec	nysician: The law nis certificate hes l I director, page 2 s	8											mpletion of cause of			
/ital	sician certifi	Be l	25. Was case referred examiner?  1  Yes 2		Hospital:		leno		T-:-	ace of Deat	,	, ,				
of \	ding Phy th, After this t funaral d	ite: To	27. Manner of Death 28a. Date of injury 28b. Time of injury at work? 2 Accident Investigation 3 Suicide 6 Could not be 28a. Place of Injury At home form street factors of first.													
Division of Vital Records,	Attanding or death. actor: After by tha funa	tifica											D. 4. North			
Divi	safter safter el Dirac ed in by	<u>s</u>	4 🗌 Homicide	determin		ing, etc. (Specify		eet, iact	ory, office			City or To	Street an wn, State	d Number	r or Hural	Houte Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edica	(Check 2	Medical Ex	Physician: To the b	sis of examinatio	n and/or inves	stigation,	in my opinio	on, death oc	curred at	the time, date	and place	e, and due	to the cau	use(s) and manner stated.
	To tha within 2 To tha comple	ž	only one) 3 29b. Signature and	☐ Certifying	Nurse Practitioner	To the best of	my knowledge	, death o	ccurred at t 9c. License	he time, date	and pla	ice, and due to	the cause	e(s) and ma ate signed	anner as s	stated.
			· d	1910	1/20					D0073	984		0	ctobe	er 08	3, 2012
	7		30. Name and addre						t Glo	n Roa	d. 9	Silvon	Sphi	na I	har uk	land 20910
	Stat	-	31. Date filed (Mont	th, Day, Year)	<b>∌</b> 32. R	Registrar's Signa	ture		- 026	n Rou	<i>u</i> , <i>z</i>	muvel.	Spice	ייש, ו	········y	20/10
	Registra	r	0014	0 9 2012	Central	2 1.	back									

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Jackie Collette Puvear

ackie Collette	r u y	otato of that yiar a r bopa	rtment of Health and Mental tificate of Death		ZUIZ JZJI g. No.				
Physic fledical Exam		Decedent's Name (First, Middle,Last)  ACCUST A DIFFERENCE OF THE PROPERTY		2. Date of Death Month September					
		JACKIE COLLETTE PUYEAR  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death				
		9526 Perry Hall Boulevard # 304	Perry Hall		Baltimore County				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 1 M 2 XF 46		Months Days Hours Min.					
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
≥	5	MD. BALTO.	NOTTINGHAM		1 Yes 2 X No				
Maryl: r 28a-f ed at o	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?				
rith the ] 123a or 23a or	al D	9526 PERRY HALL BLVD. APT. 304  11. Marital Status  12. Was Decedent Ever in U.S.	21236  3. Vas Decedent of Hispanic Origin? (	Specify Ves or No.	USA No- 14. Race - American Indian, Black,				
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygien feeth and Mental Hygien feeth and wastural?, or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once,	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puer		White, etc.				
s after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify: WHITE				
2 hours "natu		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use r		16b. Kind of Business/Industry				
036 ithin 7 are. r than	Completed	12TH	COOK		FOOD SERVICE				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last)		me (First, Middle, M	,				
212 ould be Menta marks	To Be	LOWELL D. PUYEAR  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number of	J. HEWITT or Rural Route Numi					
MD d 2 sho lth and n 27 is		BELLE J. PUYEAR MOTHE			04 NOTTINGHAM, MD.2123				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygient Important: If item 27 is marked other than injury or other traumatic event, the Medical			lace of Disposition (Name of cemetery, rematory or other place)	Date	20c. Location - City or Town, State				
Baltimore, permit. Pages I a Department of He Important: If ite injury or other ti		4 Donation 5 Other Specify: ATL 21 Signature of Funeral Service Licensee	ANTIC CREMATORY 10- 22. Name and Address of Facility SC		GLEN BURNIE, MD.				
Department of the position of		BeriGleler	9705 BELAIR ROA	D NOTTIN	GHAM, MD. 21236				
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line. Atheroscler Immediate Cause (Final disease or condition resulting in death)	Do not enter the mode of dying, such as cardiac cotic Cardiovacsular Di	or respiratory arre	st, shock, or heart Approximate Interval				
Examiner		Immediate Cause (Final disease or condition resulting in death)  The Combined to a trazodone, a pra	oxic effects of morphi izolam_and_citalopram	ine,quetia	apine, Death				
		Sequentially list conditions,  b.							
	nine	if any, leading to immediate cause. Enter Underlying Cause (C): C:  Due to (or as a consequence of)							
ed asit	Examiner	events resulting in death) Last  Due to (or as a consequence of)	consequence of):						
Division of Vital Records, P.O. Box 68760, no the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	unpended							
760, cate be physici	/Med	IF FEMALE: 23c. If yes, outcome of pregna			23d. Date of delivery				
c 68 certifi ending use as t	Physician/I	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 Ectopic preg	nancy	Month Day Year				
Boy ie death the att									
, P.O.	cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown								
'ds, require been sig	Completed		·	24a. Was ar	Was an 24b. Were autopsy findings available prior to completion of cause of death?				
ecol ne law te has l ge 2 sh	ldmo								
tal Re cian: The certificate ector, page	•	25. Was case referred to medical	26 Place of Death (Chec		10 10 2 10				
F Vit Physici rr this c	To B	examiner? 1							
on of nding P th. r: After re funera	ion:	1 Natural 5 Panding (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	unknown					
Visic or Atte her dea birecto	ificat		fd 10:55 am ne, farm, street, factory, office building, etc.	28f. Location (St	reet and Number or Rural Route Number, City				
Dispital of nours all in filled	The state of the s								
Division  To the Hospital or Attend within 24 hours after death To the Funceral Director: completely filled in by the	Medical								
To T vith	Med	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)				
	0	Patila- Poler -	O.C.M.E.	ļ	September 27, 2012				
id		30. Name and address of person who completed cause of death (Item 23a)							
<i>I</i> U	tate		xaminer 900 W. Baltimore Street,	Daillinore, MD	7 2 1 2 2 3				
Regis	trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 0 9 2012	1. park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October ELIZABETH OGDEN PRESTON 10.20 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Roland Park Place None Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours Min **Director** 213-46-3116 1 □ M 2 **XX**F 07/15/1917 Maryland 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland None Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 830 West 40th Street 21211 USA ral", or items 2 Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates "natural" 3 XX Widowed 4 □ Divorced Specify: White of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Teacher Private School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Harry Ford Ogden Mildred Broughton Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Harvey Cooper Ottley DTR 35 Mahaffey Road, Howard Springs, North Territory, Australia 0835 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2XXCremation 3 ☐ Removal from State cemetery, crematory or other place) Metro Crematory 10/08/2012 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Fur 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or composhock, or heart failure. List only an ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Immediate Cause (Final 36 heurs dougle intra-obdominal event, littly inchemic bowel Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) xaminer Years pertuaire cardinascular disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transif that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy detached for 5 Other (specify) Month Day Year 9 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementie Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate to completely filled in by the funeral director, pag 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ™ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending injury work? 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT 0 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. DSABELLE TACGRESCR, 830 W. 40th STREET, BALTINGRE, 50 21211

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) Ochsber 6, 2012

29c. License number

013651

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	000	., , ,
James Robert Parker		State of Maryland /

		1- For State Registrar	Certificate of Death Reg. No.							
Physicia edical Exami	ın/ ner	1. Decedent's Name (First, Middle,Last) James Robert Parker				2. Date of De Month October	Day 2, 2012	Year	3. Time of Death 1314 hrs	
		4a. Facility Name (if not institution, give street and number)  Baltimore Washington Medical Center		41	o. City, Town, or Lo Glen Burnie	ocation of De	ath		ounty of Deal ne Arunde	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD						///// 9. B		
Director		219-64-8450 <sub>1XM 2</sub> F	Months Days Hours Min.						55 Fore	ountry) PA
any	1	TOD: COUNTY	0c. City, Town							10d. Inside City Limits
	5	MD Anne Arundel	Seve	rna						1 Yes 2 X No
Maryla r 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 519 Evergreen Road 21146 USA					untry?			
rith the		11. Marital Status 12. Was Decedent E	ver in U.S.		Decedent of Hisp	anic Origin?			. Race - Ame	rican Indian, Black,
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2				no Rican, etc.)		White, etc.  Specify: White		
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ID 21215-0036 should be filed within 72 hours a and Mental Hygiene. 77 is marked other than "natura natic event, the Medical Examin	Be Co	17. Father's Name (First, Middle, Last) Robert C. Parker			1		M. Ada		iname)	
212 ould be I Menti	일	19a. Informant's Name/Relationship (Type, Print )			Address (Street					I
MD d 2 sho lith and n 27 is		Jean A. Parker Mother		-	Evergre		oad Sev			MD 21146 or Town, State
Imore, MD 2 Pages 1 and 2 shoulment of Health and Nant: If item 27 is no other traumatic		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State	cremate	ory or oth	er place) .c Crem		10/8/12	- 1	-	urnie MD
Baltimore, permit. Pages 1 at Department of He. Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Ligense								& Fun Serv
Balti permit. Departm Importa injury o		CAhan 111NL		Th	omasAll	lenPA	7090 F	idge	Rd H	anover MD
Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						, or heart	Approximate Interval Between Onset and Death			
Examiner	Head and neck injuries						Beaut			
		Sequentially list conditions, b								-
	iner	if any, leading to immediate Due to (or as a consect cause. Enter Underlying Cause	quence of):							
ed nsit	Examiner	vents resulting in death) Last Due to (or as a consequence of):								
760, icate be executed physician and the burial - transit	lical	d. UNPENDED AMENDED								
760, cate be physic the bur	/Medical	IF FEMALE: 23c. If yes, outcom	e of pregnancy		.1.4# 2 [	Ectopic pre	anancy		Date of delive	ery Day Year
X Company of the past 12 months?    The past 12 months   Pregnant at time of death   P									nut buy rous	
Boy te death the att	Physician	Part II. Other significant conditions contributing to death	h	a in the u	ndoch ing causo gi	ven in Part I	23e Die	1 tobacco us	e contribute	to the cause of death?
i, P.O. E ires that the d signed by the	þ	Part II. Other significant conditions contributing to death	but not resultin	gintileu	riderlying cause gi	veri ii i aiti.				obably 4 🗹 Unknown
of Vital Records, P. ng Physician: The law requires the African that certificate has been signe neral director, page 2 should be de	Completed							as an topsy		autopsy findings available completion of cause of
Recol The law cate has	dmc						<u> —</u>  ре	rformed? s 2 No	death′	
tal Re- tian: The certificate	Be C	25. Was case referred to medical	ise referred to medical 26.Place of Death (Check only one)							
Vital Physician: r this certif	70 E	examiner?  1 Ves 2 No  Hospital: I Inpatient 2 ER/Outpatient 3 DOA  Other, Nursing Home 5 Residence 6 Other.  28a Date of loury 28b Time of Injury at Work? 28d Describe how injury occurred								
Sion of Attending Ph T death. ector: After t by the funeral								otor vehic	le involved in motor	
Division tal or Attendi rs after death.	ficat	2 V Accident  1 Investigation 3 Suicide  Could not be  Could not be  Could not be  See. Place of Injury - At home, farm, street, factory, office building, etc.  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rur or Town, Street)								
						Benfield Bo	enfield Boulevard and Veterans Highway, Severna Par			
To the Hos within 24 h To the Fur completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the							the cause(s)		
To t with To t	29b. Signature and title of certifier									
		Thoday W. Kind J	Ryner	6.	O.C.N	И.Е.	OCME	Octob	ber 4, 201	2
101		30. Name and address of person who completed cause of d. Theodore M. King, Jr., MD. Assistant M.		niner	900 W. Baltim	ore Stree	t, Baltimore.	MD 2122	3	
101	tate			pa			-, =			
Regis		1	. A.	Dan	No.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 32319 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 7, Day 2012 Year 12:28 A M Judith D. Rheiner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Tate Hospice House Linthicum Heights 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Director 560-58-1213 1 □ M 2 🗓 F Yrs. 72 Sept. 25, 1940 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show amy hiury or other traumatic event, the Medical Examiner must be notified at once. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Anne Arundel Millersville 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 21108 United States 467 Old Orchard Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 ☐ Never Married 2 🎇 Married 1 ☐ Yes 2 No Specify. If Yes, Give White Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Motion Picture Publicist Motion Pictures Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Muriel Rosenboom Maynard Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Rheiner (Husband) 467 Old Orchard Circle, Millersville, MD 21108 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Metro Crematory, Inc. 10/8/2012 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 21. Signature of Juneral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ reast Cancell disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 12 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mersenbes Messens 0-8-701 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Meisenberg, 2001 Medical Pkwy., Donner Pavilion, Annapolis, MD 21401 31. Date filed (Month, Day, Year) State OCT 0 9 2012 Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Shelia A. Ross notos 07:08 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Balti more at Hospital of Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Birthplace (State or Foreign Country) Hours (Month Day 39a-7 215-46-6229 MD Director 1 ∏м 2 🕅 Б 65 ira!", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 2900 Edgecombe Circle South USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify. SpecifyAfrican-American Completed 3 🗆 Widowed 4 💆 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Network Engineer Verizon Commincations Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked any Injury or other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marjorie Ross Charles Westley Cornish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Powell/ Daughter 9615 Brie Road, Randallstown, MD 21133 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 10-12-2012 Woodlawn, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signatum of Funeral Service License 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications test caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple Physician/ disease or condition resulting in death) month Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funerai Director: After this certificate has been siy completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death. Funeral Director: After the 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

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Shelia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g932 10-9-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Bete of Death Gladys R. Sherman Ruddie Physician/ 9.00 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ATRIUM VILLAGE OWINGS MILLS BALTIMORE Birthplace (State or Foreign Country) Funeral Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours Director 047-18-9997 1 □ M 2 🕅 F Yrs 93 08/30/1919 CT permit. Page 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f ehow any injury or other traumetic event, the Medical Evaminar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No PALM BEACH BOYNTON BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8079 DOLMITIAN WAY 33472 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Š 1 ☑ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DENTAL HYGIENIST DENTISTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ LUNTZ BENJAMIN FLORENCE BOROFSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISRAEL RUDDIE/HUSBAND 4730 ATRIUM COURT, OWINGS MILLS, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK: 10/07/2012 RANDALLSTOWN, MD 21. Signature July al Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TREBRO VASCULAR Physician/ THEROSCLEROTIC BASEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any beeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of siclan and burlel-trensit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician I for use as the burle Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Yes 2 No g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that within 24 hours after deeth.

To the Funeral Director: After this certificete has been signed completely filled in by the funeral director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed | 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2/ No autopsy perform Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗌 Yes 20 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 14 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 28595 nu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM (AKIHANI, MI) 4 6 Box 1525 ASNEEM WINGS MILL 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First\_Middle\_Last) 2. Date of Death OCTOBER Physician/ Day (LOSRN Konald 2012 Frankl 2:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ALICE MANOR NURSING HOME BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Months (Month, Day, Year) Hours Country) Director 219-10-3877 1 XM 2 □ F 86 12/27/1925 MD 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified 1 √ Yes 2 □ No N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2095 ROCKROSE AVENUE 21211 IISA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed Specify: 3 ♥ Widowed 4 Divorced WHITE Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) OWNER BOOK STORE Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed trent of Health and Mental H tant: If item 27 Is marked ot jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ROSEN SADIE ROSENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREGORY FEIT/GRANDSON 3664 HERON RIDGE LANE, WESTON, FL Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) BETH EL MEMORIAL PK 10/07/2012 RANDALLSTOWN, MD . Signature of Funeral Service Lices 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or #8 a consequence of) Éxaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician: The law requires that the death certificete be executed Cause (Disease or injury that initiated events use as the burial-trar resulting in death) Last Due to (or as a consequence of) igned by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2X□ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury of Funeral Director: Af e Funeral Director: Af oletely filled in by the fu 1 Yes 2 🗆 No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) D70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITSANI STL CVAW

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's Sgnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** usse C 2012 om liam /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ARNOLD (AII) 305 College 1012 PWY If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 10 1 2 F **Funeral** Hours Months Days 02/25/1935 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Glen Burnie Anne Arundel Co. MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21061 385 Jaybea Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 X Married 1 ☐Yes 2X No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Religious Store Clerk 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental Hem 27 Is marked otlether traumatic even Ellen Hegder Mary Russell, Sr. Thomas ပ William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21061 Glen Burnie, MD 385 Jaybea Court permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once. Wife Mrs. Janet L. Russell 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 10/10/2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral S Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE RENAL DISEASE DEPENDENT DYALISIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CORONARY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ANTERY DISEASE PERIPHERAL autopsy performed? Yes 2 No 2 □ No 1 ∐ Yes 1 ☐ Yes DIABETES TYPE 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pendina 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/5/12 0062395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

ALPONSO A GOVMAR

31. Date filed (Month, Day, Year)

ORIGINAL

AVIATION BLVD SUITE B GLEN BURNIE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sriv Reth 9:19 am October 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 577-04-2945 Director 1 M 2 X F Yrs 84 08/09/1928 Cambodia Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Ashton 1 🗆 Yes 2 🕱 No Maryland Montgomery 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20861 u.s.A. 17437 Avenleigh Drive or items 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural" 3 X Widowed 4 Divorced Specify: Asian Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Huor Seng Reth You Chhay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, .8 Page 1 and 2 sl ment of Health a 17437 Avenleigh Drive, Ashton, Maryland 20861 Malinda Suon-Sok/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Burial 2 Cremation 3 Removal from State 10/10/2012 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Acute Respiratory Failure disease or condition Medical resulting in death) Examiner Cardiogenic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Septic Shock and -tran Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Aspiration Pneumonia Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown Day Month Year 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Dementia 1 Yes 2 No 3 Probably 4 No Unknown Completed Urinary Tract Infection 24b. Were autopsy findings available prior to completion of cause of autopsy death? Anemia Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending death. 1 Yes 2 No Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours a Hospital Medical 29a. Certifier 1 🛴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

comple only one 29d. Date signed (Month, Day, Year) 29b. Signature and tit 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) BROWN 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year,

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year JoAnn Louise 2012 Roth October  $P^{M}$ 2:34 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min. (Month, Day, Year) Director 215-20-2813 1 M 2 X F 85 November 26, 1926 Usual Residence of Decedent Maryland shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or then "neturel", or items 23e or 28e-f si the Medical Examiner must be notified Maryland 1 Yes 2X No Montgomery Brookeville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19104 Treadway Road 20833 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Supervisor Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Reed Hattie Jane (Not Available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health ( permit. Page 1 end 2: Department of Health importent: if item 27 eny injury or other troone. Johnie F. Roth, Jr./Son 19104 Treadway Road, Brookeville, Maryland 20833 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico National Cemetery Oct. 11, 2012 4 ☐ Donation 5 ☐ Other (Specify) Triangle, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Tuneral Home/Bethesda-Chevy Chase, Inc. The J. Ann M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Pneumonia with Respiratory Failure Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospitel or Attending Physician: The lew requires that the death certificete be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box Ectopic pregnancy in the past 12\_months?
1 ☐ Yes 2 🕅 No
9 ☐ Unknown Day 5 Other (specify) Joann Louise 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ <u>Parkinson's Disease</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 [X] No Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 1026

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who completed

QCT 0 9

31. Date filed (Month, Day, Year)

Anitha Pesala Chetty,

M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32326 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6, 2012 1:40 AM Lawrence George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11224 Empire Lane Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) Director 573-90-4000 1 ፟፟፟፟M 2 ☐ F 59 Nov. 3, 1952 New Jersey 1 and 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene.
item 27 is marked other than "naturel", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 11224 Empire Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify: 3 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Diplomat U.S. Government Be permit. Page 1 and 2 should be file.
Department of Health end Mental H
Important: If item 27 is marked oth
any injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald John Rossin Ruth McCormick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Jane McGowan / Wife 11224 Empire Lane, Rockville, Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of October 9 20c. Location - City or Town, State Montgomery

Contgomery 1 Burial 2 X Cremation 3 Removal from State Crematoriúm, Bethesda, Maryland 4 Donation 5 Other (Specify) 2012 Inc. 21. Signature Funefal Servi Robert A. Pumphrey Funeral Home, Rockville, M01619 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
1/2 years Immediate Cause (Final Physician Multiple Myeloma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Exami To the Hospitel or Attending representations within 24 hours after death.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending Work! 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 8, 2012 D42593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Room N9E12, Baltimore, Maryland 21201 Ashraf Badros, M.D.

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ieloise Riddell		State of 1- For State Registrar	Maryland / Depa <i>Cer</i>	artment of rtificate of			Reg. No. 201	2 3232
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) Heloise Riddell				2. Date of De		3. Time of Death
		4a. Facility Name (if not institution, give stre 1410 Kensington Drive #203	eet and number)	4	b. City, Town, or Location of Hagerstown		4c. County of Dear	
Funeral						24Hrs. 8. Date of B	Washington irth(MM/DD/YYYY) 9. Bi	rthplace (State or
Director		$475-39-4092$ $_{1 \square M}$ $_{2 \boxtimes F}$ 51			Months Days Hours	Min. 05/0	5/1961 Fore	gn South Duntry) Africa
y any		Usual Residence of Decedent  10a. State 10b. County		Town or Location				10d. Inside City Limits
Maryland 28a-f show	ctor	MD Washingto	n Ha	gersto	WN 10f. Zip Code		10g. Citizen of What Cou	1 Yes 2 X No
with the Maryland ms 23a nr 28a-f sho be notified at once.	Director	Unk			21740		USA	mu y :
eath with items 2.	Funeral	11. Marital Status 1 Never Married 2 Married	Was Decedent Ever in U. Armed Forces?		Decedent of Hispanic Origin s, specify Cuban, Mexican, F		White, etc.	rican Indian, Black,
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215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked nther than "natural", or items 23a nr 28a-f she ent, the Medical Examiner must be notified at once	Completed		College (1-4 or 5+)	during mo	s Usual Occupation (Give kir st of working life. DO NOT us	nd of work done se retired)	16b. Kind of Business	•
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21215-00 buld be filed with I Mental Hygiene I marked other	Be	Edward Pistorius  19a. Informant's Name/Relationship (Type,	Oried )	40h Mailian	Address (Street and Numb	ınk		
MD 2 42 shoul th and N 27 is n	٩	Sharon SheeleyAu			adway Apt I		stown MD :	21740
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition  1 Burial 2 X Cremation 3 F	emoval from State A +	Place of Disposit rematory or other Lantic	ion (Name of cemetery, er place)	Date	20c. Location - City of 2 Glen But	•
Baltimo permit. Page Department or Important: injury or oth		4 Donation 5 Other Specify: 21. Smature 1: Funeral Service Licenses	71		me and Address of Facility			
m ஐஃ்.∄.்≘ Physician	() [2	23a. Part I. Enter the disease, or complication	ons that caused the death.		omasAllenPA			anover MD Approximate Interval
Medinal Examiner	- 3	failure. List only one cause on each lir Immediate Cause (Final disease a. Sho	<sub>le.</sub> tgun Wound of Che					Between Onset and Death
. 6		or condition resulting in death)  Due 1  Sequentially list conditions,  b.	o (or as a consequence of	):				
	Examiner		o (or as a consequence of	):				
uted Id ransit		events resulting in death) Last  Due t	o (or as a consequence of	):				
50, ite be executed nysician and burial - transit	Medical		ENDED					
30x 6876 death certificate e attending phy for use as the l	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregn	2 Feta	I death 3 Ectopic p	regnancy	23d. Date of deliver Month	y Day Year
Box te death c the atten ted for us	Physic	1 Yes 2 No 9 V Unknown 9	Pregnant at time of dea	5 Othe	er (Specify)			
Division of Vital Records, P.O. Box 68760, the Hospital nr Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial – transi	ā	Part II. Other significant conditions cont	ributing to death but not re	sulting in the un	derlying cause given in Part	12	obacco use contribute to s 2 ✓ No 3 Prol	
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tal Reco	Š					perfo	ormed? death? 2 No 1 Ye	
Vital Rec ysician: The I his certificate director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	al: 1 Inpatient 2 I	ER/Outpatient	26.Place of Death (Cl	heck only one)  Jursing Home 5	Residence 6 🗸 Othe	r: Scene
iding Phy. h. : After the funeral		27. Manner of Death	8a. Date of Injury (Month, Day,Year) FOUND:	28b. Time of Inju	ury 28c. Injury at Work?	Subject che	how injury occurred ot self	-
visior nr Attend fler death Director: in by the	Certification	2 Accident Investigation		1000 hrs me, farm, street,	factory, office building, etc.		Street and Number or Ru	rat Route Number, City
Divi		29a. Certifier	(Specify) Single Fam		d at the time, date and place	1410 Kensing	ton Drive #203, Hage	
Divi: To the Hospital nr / within 24 hours after To the Funeral Dire	edica	one) 2 Medical Examiner: On t			n, in my opinion, death occur		and place, and due to th	e cause(s)
	2	29b. Signature and title of certifier	DAW		29c. License number O.C.M.E.		29d. Date signed (Mo September 3, 20	
	ŀ	30. Name and address of person who compl	•	,	Minness Observed D. M.	AID CACC	<u> </u>	
		31. Date filed (Month, Day, Year)	32. Fegistrar's Signatur		altimore Street, Baltim	ore, MD 21223		
Regist		UCT 0 9 2012	Deneva p	1. par	النا			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:09 AM Sharon Suggs Ochober 2017 Medical 4c. County of Death **N/A** 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Hospital Baltimore Rallimore Sina 01 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 06/06/1957 220-68-4840 55 1 □ M 2 🔀 F **Director** Maryland Usual Residence of Decedent show d at 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Baltimore 1X Yes 2 No MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 21215 U.S.A. 2501 Violet Ave. Apt 1004 N Sharon 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, "natural", or iter Black White etc Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 College (1-4 or 5+) 2 years Elementary/Secondary (0-12) Mental Hygiene. Medical Records Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mabel Moore William Suggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Tentmill Apt F, Pikesville, MD 21208 Carolyn Powell(sister) permit. Page 1 and 2: Department of Health Important; If item 27 any injury or other troonee. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/09/12 Baltimore, MD 4 Donation 5 Other (Specify) 305epAddffs Brown Jr. Funeral Home PA 21. Signature of Faneral Service License MD21217 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner cours Ischemic Sequentially list conditions, Examiner if any, leading to immediate cause. E. ter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Cardio Dulmonary burial-transi and Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No detached for Pregnant at time of death 1 Yes 2 9 Unknown 9 | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe disease hemodial Yes 2 No this certificate on 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No ၉ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending efter death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital of within 24 hours at To the Funeral to Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number MBBS RES - 000 Ochober 03 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINGH HOS prola Sinou NAMITA MBBS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

KNOWN

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Day 4a. Facility Name (if not institution, give street and fumber) Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Hours 216-30-0/62 Director 1 M 2 - F 8 MD 09-01-1934 r than "natural", or items 23a or 28a-f show the Medical Examirer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No BATIMORE MD 10e. Street and Number 10g. Citizen of What Country? Funeral AVENUE WINSTON 21212 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) STELLA MARIS Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Smith Irma Bradford Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD121212 M. Smith WIFE AVE. ornelia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any Injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 10/17/12 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUBHN GREENE FUNERAL SLVS 21. Signature Funera Service Licensee MU1665 ROAD. BALTIMORE, MD. YORK 23a. Part 1. Enter th sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Due to (or y a consequence of) disease or condition resulting in death) Medical Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end for use as the burial-transit Due to (or as a consequence of) Physiclan/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death cate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 1 N 1 Yes 2 🗆 No **Division of Vital** completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🕽 No ၉ 1 Nonpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 \sum Yes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 3435 (OHIO) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+1V 31. Date filed (Month, Day, Year) 32. Registrar's State 9 2012

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Daterof Death Physician/ am Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown 3813 Pikeswood Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 180-18-2578 Director 1 ▼ M 2 □ F Yrs. Jul. 14, 1922 90 Pennsylvania Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 3813 Pikeswood Drive 21133 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 \sum No
If Yes, Give 1942-46 Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hyglene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Automotive Sales Company Representative Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Louis Schweriner Catherine McCloskey Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 3813 Pikeswood Drive, Randallstown, MD 21133 Gladys Schweriner (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If Ite
any injury or ott Date 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 10/8/2012 Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Alyson Taylor 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): for use as the burial-transit that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury after death. 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

5 State

Maryland 21215-0036

Baltimore,

Box 68760

of Vital Records,

Division

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year,

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 30, Vear 30, 2012 ennings 1:45 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CENTER MINT-TOSEPH MEDICAL Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min. Country) Director 1 X M 2 □ F 83 214-26-4179 Jul 13, 1929 Maryland 28a-f show 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore Parkville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiens in a nours after death with in portant: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event Funeral 2722 Burridge Road 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 KNo Specify: Completed 3 

Widowed 4 □ Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dept. Of Navy Computer Specialist Be Baltimore, Maryland filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Elmer Slaughter Rose Robel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Slaughter /Son 905 Dellwood Drive Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Oct 0 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 Signature of Funeral Service Licensee 22. Name and Address of Family Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA €hysician/ TERAL WEEKS Medical Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): for use as the burial-transit Division of Vital Records, P.O. Box 68760 L. Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate filled in by the funeral director, pag performed' Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 K No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) MA 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER TOWSON MARYL 31. Date filed (Month, Day, Year)

Registrar

ELMER JENNINGS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 Month be Physician/ 10m0 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Ve If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Country. 220-36-4120 1 M 2 🗆 F Director irginia permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 502 UCIA 12. Was Decedent Ever in U.S. Armed Forces?

1. Yes 2 \sum No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2AVENS Elementary/Secondary (0-12) College (1-4 or 5+) evator Atten dan 214 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည ralden 19a. Informant's Name/Relationship (Type, Print) \_ Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sea Pines circle Kandaelrtmin, mD: 21133 ArnoLD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 11, 2012 OWINES MILLS barns in folest vet. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3405 W. Franklein 21. Signature of Funeral Service Licensee Balto, md, 21229 Nancy m. Wallace F.S. 23a. Part + Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minuta Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence off To the Hospital or Attending Physician: The law requires what the bound to write the death, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE. yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗹 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death opage, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0041514 Heman 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 N. Greene V-Balleman, MD ,10

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

OCT 0 9 2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Sines October 2012 415 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death erroll Carroll Hospital Co Westminster nter 9. Birthplace (State or Foreign Country) MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 28 7. Age (In yrs. last birthday) **Funeral** 216-20-9809 1 □ M 2 🏋 F 86 Director Usual Residence of Decedent 28a-f show Shourd be more land Mental Hygiene.
I smarked other than "natural", or items 23a or 28a-f show it is marked other than "natural", or items 23a or 28a-f show it is marked other the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Svkesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 Apt 306 USA 7426 Village Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 X Widowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 accounting clerk accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Aloywishes Dorn Bertha Nazer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important; If item 27 is
any injury or other trau Mrs. Kathy Harden (daughter) 7716 Gaither Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State All County Cremation | 10-6-12 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility Haight Funeral Rome & Chapel 21. Signature of Funeral Service License ▶ Page Jaget Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Myocardial Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical  $Box 68760^{C}$ IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congetive Heart Failure, CABG, Hypertension, Be Completed 1 Yes 2 No 3 Probably 4 Unknown Hyperlipidamia, Atrial Fibrillation, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? Hypertension 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69086 October 5, 2012 MD

State

Registrar

Curroll Hospital Center 200 Memoral Are, Welminter MD 24857

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CHINTU SHARMA MD

OCT 0 9 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O CLOVE Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Center Baltimore If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs (Month, Day, Yea Aug 29, ] 217-09-7340 94 **Director** 1 M 2 X MD 1918 28a-f shov iral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ANo MD Baltimore Perry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 4206 Winterode Way hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White "natural", 3 ▼ Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Electrical Supervisor City of Baltimore other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Metuling Albert C. Scrimger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important; If item 27 is: any injury or other transone. (son) 4206 Winterode Way, Perry Hall, MD 21236 Mr. Albert M. Scrimger, Jr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 10/11/2012 Sykesville, MD Lake View Mem. Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 400764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 0928 Ph sician/ neunonea disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last The law requires that the death certificate be exe Physician/Medical Division of Vital Records, P.O. Box 68760 phys the l attending properties of the second IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Day 5 Other (specify) Yes 2 No ed by the a detached g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 20 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 💆 No Other 1 Yes ျပ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work' 5 Pending n 24 hours area we he Euneral Director: After an Interest filled in by the fu 1 Tes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2

To the I

comple Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29d. Date signed (Month Day, Year) 2012 oclober 30. Name and address of person who completed cause of death (Item 33a) (Type) Print)

Registrar DHMH 17 Rev 06-2011

State

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31. Date filed (Month, Day, Year,

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2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 2:33 AM M September <u>Leanna B. Struzzierv</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fredeick Kline House Hospice Mt. Airy If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday 8. Date of Birth Davs Hours (Month, Day, Year) Director 492-82-3482 1 □ M 2 💢 F 33 Usual Residence of Decedent Mar 27. Missouri 28a-f show 10b. County 10c. City, Town or Location 10d Inside City Limits by Funeral Director be notified Frederick 1 Yes 2 No Frederick 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a 143 W. South Street must k 21701 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian event, the Medical Examiner Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 X Married ō within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes Give "natural". 3 🗆 Widowed 4 🗆 Divorced Completed white Year or Dates 15. Decedent's Education (Specify only highest grade completed, unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than enviromental I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) planning 1 and 2 should be filed w f Health and Mental Hygi item 27 is marked othe Be 17. Father's Name (First, Middle, Last, unk unk 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 W. South Street Frederick, MD Herbert Wright 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee

Ronald S Wade Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore. ΜĎ 23a. Patr 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Years Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Box 68760 as the IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Month Pregnant at time of death signed by the at Id be detached for 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death?
1 Yes 2 No Yes funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗶 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DQA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Hospital or Attending Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide filled in by the Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) P

Registrar
DHMH 17 Rev 06-2011

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30. Name and address of person who con

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ John Dean Smith 2012 October 4:00 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford County 2635 Thomas Run Road Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 214-36-7779 **Director** 1**X** M 2 □ F 74 February 17,1938 West Virginia Usual Residence of Decede 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Harford County Bel Air 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21015 United States 2635 Thomas Run Road permit. Page 1 and 2 should be filed within 72 hours after death verbeartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Manager 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Edoewood Arsenal Chemical Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Lester Smith Lytha Louvene Haynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duane Smith (Son) 3721 Salem Church Road, Jarrettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Dublin Missionary Cemetery Oct. 11, 2012 Dublin, Maryland Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
23. Name and Address of Facility
24. Name and Address of Facility
24. Name and Address of Facility
25. Name and Address of Facility
26. Name and Address of Facility
26. Name and Address of Facility
26. Name and Address of Facility
27. Name and Address of Facility
28. Name and Address of Facility
28. Name and Address of Facility
29. Name and Address of Facility
20. Name and Address of Facility 20 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ esophu disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 L Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year signed by the at d be detached for Yes Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 After this certificate has autopsy performed' 1 Yes 2 No Yes 2 No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of 29d. Date signed (Month, Day, Year) 6/2 D0066282 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Venkata Parsa, M.D. 510 Upper Chesapeake Drive Bel Air, Maryland

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death october 5 Day 2012 Year Physician/ 7:23 A M Sondra G. Stafford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A 108 S. Castle Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days Hours 1 □ M 2.X 1 10/2274942 69 Director 151-32-3873 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 S. Castle Street 21231 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗆 Divorced Specify: White Year or Dates. Unic. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Director of Donations Non-profit organization Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Stafford Lillian Graff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexis Johns - Friend 110 S. Castle Street Baltimore, Maryland 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/06/2012 Glen Burnie, Maryland 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service Licensee Enter the diseas complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on such line. Onset and Death Immediate Cause (Final Ph sician/ Darcinona TRIMAN 6 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a nonsequence of, Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tyes 2. No 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2  $\square$  No 2 Accident 3 Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completed cause of death (Item 23a) (Type, Prot

Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October 12:05A M Beatrice Mae 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. cial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-44-6781 **Director** 1 □ M 2 🗓 F 94 Aug. 10 1918 Iowa Usual Residence of Decedent 28a-f show ms 23a or 28a-f shormust be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 USA 1202 Will-O-Brook Drive "natural", or items edical Examiner mu Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Anderson Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 
1202 Will-O-Brook Dr., Pasadena, MD 21122 JoAnn M. Campbell (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 20c. Location - City or Town, State Oct. Date 09 1 🔲 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Baltimore, MAryland 2012 permit. 21. Signature of Funeral Service Lig 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 MOuntain Road, Psaadena, MD 21122 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause or that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last ttending physician for use as the buria Physician/Medical Physician: The law requires that the de th certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Live Birth 4 Pregnant at time of death 3 Ectopic pregnancy signed by the atte in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 P No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No al or Attending Physics after death. Director: After this or 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Funeral 1 Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOUNTAIN ROAD, 4304 GARG an 32. Registrar's

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar					201	2 32339
			Reg. No. 2 U  1. Decedent's Name (First, Middle, Last)  2. Date of Death							3. Time of Death
Sm	Physicia Medic		Nancy	211			October	Day Year		
	Examir	ner	4a. Facility Name (if not institution, University of M	give street and number) any land Medica	al Center	4b. City, Town, or Baltimo			4c. County of De	eath N/A
	Funeral Director		5. Social Security Number 214–50–1093  Usual Residence of Decedent	7. Age (I	n yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day March	1 1946 9. E	Birthplace (State or Foreign Country) MD
	rland f show d at	tor	10a. State 10b. County	1	0c. City, Town or Lo		_	1		10d. Inside City Limits
	r 28a-i notifie	Direc	Maryland Anne  10e. Street and Number	Arundel			adena ———			1 Yes 2 No
	s 23a o	eral	972 9th Street			10f. Zip Code	21122		10g. Citizen of What (	USA
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1  Never Married 2 Marrie 3  Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates.		Vas Decedent of His f Yes, specify Cuban ☐ Yes 2 XNo		ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, lite, etc. White
21215-0036	vithin 72 hou iene. ir than "natu the Medica	Complet	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12		(Give	lent's Usual Occupa kind of work done du O NOT use retired) Yroll Tec	iring most of work	ing	16b. Kind of Busines Insurance	s/Industry C Company
Maryland 2	2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "traumatic event, the Med	To Be	17. Father's Name (First, Middle, La	offin			18. Mother's Nam	ne (First, Middle, M	Maiden Surname) ylor	
Mar	12 shoul lith and I 27 is m r traum:	7 1	19a. Informant's Name/Relationship  Byrum Swindall	o (Type, Print) (spouse)		ig Address (Street ar 9th Stre			City or Town, State, 2	Zip Code)
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Sp		20b. Place of Dispo	sition (Name of	oct.	Date 11	20c. Location - City of	or Town, State  MAryland
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service I		22	Name and Address	of Facility S Intain RC	Stallings bad, Pasa	s Funeral ladena, MD	Home, P.A. 21122
	Prysician/ Medical Examiner	iner	23a. Part 1. Enter the disease, or or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to increase. Enter Underlying	a. Due to (or as a co	eding			or respiratory arre	est,	Approximate Interval Between Onset and Death
092	Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):					
. Box 687	he death certifica y the attending p iched for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of the street of the st	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
ds, P.O.	requires that the dec been signed by the s should be detached	þ	Part II. Other significant condition	s contributing to death but i	not resulting in the u	nderlying cause give	en in Part I.			to the cause of death?  Probably 4 Unknown
of Vital Records,	ician: The law re certificate has be rector, page 2 sh	Completed	25. Was case referred to medical					24a. Was al autops perfori 1 \(\sum \) Yes	sy prior to	utopsy findings available completion of cause of es 2  No
/ita	ysician: s certific director,	To Be	examiner?  1  Yes 2  No	Hospital:	2  ER/Outpatien	Other	ce of Death (Chec		ence 6 🗆 Other (Spe	
of	ding Phy h. After thi funeral		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Y	28b. Time of	28c. Injury a			ow injury occurred	ecny)
Division	I or Attend after death Director: A d in by the	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be			es 2 🗆 No	28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical	(Check 2 \( \subseteq \text{Medical Ex} \)	hysician: To the best of my aminer: On the basis of exan urse Practitioner: To the be	nination and/or invest	igation, in my opinion	, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated.
	To the complete compl		29b. Signature and title of certifier	Phra M:		29c License r	umber	2	29d Date signed (Mon	th Day Yoarl
(			30. Name and address of person with Adnam Khera		n (Item 23a) (Type, P Greene	rint) S.t.	Baltima	re. M	october O	1
	Stat	C	31. Date filed (Month, Day, Year)		Signature		MIII W	, , ,	2 2150	•
	Registra	ar	OCT 0 9 2012	Charles B.	garre					

DHMH 17 Rev 06-2011

12-07507 Unk Unk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

JNK UNK		For State egistrar	or Maryland /	•	ficate of De				1. No. 201	2 3234
Physician/ Medical Examine	1	. Decedent's Name (First, Middle,La Dimitri	A.	State	en			Date of Death     Month     October 3,	Day Year 2012	3. Time of Death 2331 hrs
	4	a. Facility Name (if not institution, given University Hospital	ve street and number)			y, Town, o timore	r Location of Deat		4c. County of Deat	h
Funeral Director		-		(In yrs. last		nder 1 Ye			-75 Forei	
und show any occ.	1	Usual Residence of Decedent  Oa. State 10b. County  MD NA			own or Location timore					10d. Inside City Limits 1 Yes 2 No
the Maryland sa or 28a-f she otified at once	1	0e. Street and Number 5513 Moravia Ro	ad		10f.	Zip Code 2120	6	100	g. Citizen of What Cou USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be incified at once.  To Be Completed by Funeral Director	: -	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorce 15. Decedent's Education (Specify of	1 Yes 24 If Yes, Give Year or Dates:	No	If Yes, sp	ecify Cuba	ation (Give kind of	o Rican, etc.)		
5-0036 ed within 72 hours lygene. other than "natu the Medical Exan Completed		12th Grade	College (1-4 or 5 NA	i+)	Coo		e. DO NOT use ref		Southern	Blues
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		7. Father's Name (First, Middle, Las Charles	Ellic	ott			Shirley		Staten	
MD 21 nd 2 should alth and Me in 27 is ma "aumatic ev		9a. Informant's Name/Relationship ( LaTonya Louden-C			7510 Tw			t Apt.	E Rosedal  20c. Location - City o	e, Zip Code) .e, MD.
Baltimore, MD permit. Pages I and 2 sho permitent of Health and Important: If item 27 is injury or other traumati		2	r:	. cre	matory or other pla odlawn Co Zion Cen 22 Name	ice) effi. eter and Addres	ss of Facility W	-12 <b>-</b> 12	doodlawn Lansdowne RAL HOME I	MD
Physician //wegicar	2	3a. Part I. Enter the disease, or comfailure. List only one cause on e	ach line.		o not enter the mo					Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease a or condition resulting in death)	Multiple Gunsho		S					Deau
ted Insit Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last	Due to (or as a conse							
60, tte be executed trysician and e burial - transit	-		1 445NDED#5.T	er IN	F,g933 1 rFH.G932	l-2-1	2 sm	· ·		
	2	F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	23c. If yes, outcom  1 Live birth  4 Pregnant at	ne of pregna	ncy 2 Fetal de	ath 3			23d. Date of delive Month	Day Year
P.O. E s that the d gned by the e detached	2	Part II. Other significant conditions	contributing to death	but not resu	ulting in the underl	ying cause	given in Part I.		pacco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 687, and or Attending Physician: The law requires that the death certifical birector: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the rification: To Be Completed by Physician/	Para la							24a. Was al autops perform 1 Yes 2	sy prior to ned? death?	utopsy findings available completion of cause of 'es 2 No
f Vital   Physician: or this certif ral director, To Be (	1	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital: 1 Inpatie	nt 2 🗸 E	R/Outpatient 3		Other Nursi	only one)	Residence 6 Other	er:
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2		27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	28a. Date of Inju FOUND: Tion Oct 3, 2012	ear) F	8b. Time of Injury FOUND: 2055 hrs		ury at Work? Yes 2 ✔ No	28d. Describe he Subject shot	ow injury occurred	
Division o ospital or Attending hours after death. meral Director: After y filled in by the fune Centification:		3 Suicide 6 Could no determin	28e. Place of In		ne, farm, street, fac	tory, office	building, etc.	or Town, Sta		ural Route Number, City ore, MD
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examination)	cian: To the best of mer: On the basis of exame and manner stated.	y knowledge mination and	e, death occurred a	the time,	date and place, an	d due to the cause at the time, date a	and place, and due to t	he cause(s)
T S I S		29b. Signature and title of certifier					.M.E.		29d. Date signed (M October 4, 2012	
		30. Name and address of person who	completed cause of d			reet, Ba	ıltimore, MD 2	1223		
State Registra	e	31. Date 514 (Nonth. 2012)	32. Registr							-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05 Day Month 10 2012 07:11 p<sup>M</sup> Schiappacasse Josefina Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 10/10/1931 Director 212-46-9509 1 M 2 V F 80 Argentina show 10d. Inside City Limits permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene.

Importent: If item 27 is marked other than "netural", or items 23e or 28e-f shown in highly or other treumetic event, the Michical Exp. it is a notified at once. 10a. State 10b, County 10c. City, Town or Location Director 1 Yes 2 X No Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S.A. 21221 8815 Goldentree Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 🗓 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Seamstress Garment Be '. Father's Name *(First, Middle, Last)* Unknown 18. Mother's Name (First, Middle, Maiden Surname) ൧ Giglio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7104 Springhouse Lane Chestnut Hill Cove, MD 21226 Richard Schiappacasse, Son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or othe Gardens ofFaith 1 X Burial 2 Cremation 3 Removal from State 10/08/2012 Baltimore, MD 4 Donation 5 Other (Specify) Leonard J. Ruck, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 5305 Harford Road, Baltimore, MD 21214 Ma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MINTH NON SMAL Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician end for use as the burlal-transit Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month 4 Pregnant at time of death efter death. **Director**: After this certificate has been signed by the ai d in by the funeral director, pege 2 should be detached f Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? POTHY POIDISM 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-10 SP1 (Control of the Control of the Cont 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 잍 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: or Attending 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours eft To the Funeral Dis completely filled In Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year 32. Registrar's Signature State OCT 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October Day Year 2 , 2012 Physician/ Wallace 2. 2:30 P.M Saunders Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** re's Hospital Geor Prince George's Prince Center Cheverly If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 221-16-4352 Director 1 🛣 M 2 🗆 F Dec. 1, 1926 Virginia 85 Usual Residence of Deceden 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City. Town or Location should be filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 X No Dundalk MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 23a 21222 United States 7002 Mornington Road Apt. D 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. of Health and Mental Hygiene.
item 27 is marked other than "natural", or iter
other traumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) General Mills Corp. Factory Worker 12 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nannie Morris Lorrenza Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria Wilkerson (Daughter) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trai 7002 Mornington Road Apt. D Dundalk, Maryland 21222 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State <u>Service Corp. 10/12/2012</u> Towson, Maryland 4 Donation 5 Other (Specify) **X**top 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.

Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signy 7922 Wise Ave Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ myocardia disease or condition acute Medical resulting in death) Due to (or as a consequence of): **Examiner** Vomitina Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical ertensic. Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 2 No 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ane mia autopsy Hospital or Attending Physician: The law page 2 death?
1 Yes 2 No Coronary arter Yes 2 🔄 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ s after death.
I Director: After this ed in by the funeral d After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a, Certifier □ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 750

October 2, 2012

MD

3001 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stahl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 3:50 P M Oct. Dorothy Betty Szimanski Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Co. Gilchrist Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funera (Month, Day, Year) Months Days Hours Director 213-07-1988 1 □ M 2 🏻 F Feb. 6,1936 Yrs Maryland 76 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Bel Air MD Harford 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 United States 1909 Emmorton Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Dependant 8 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Lillian Kensicki John Szimanski 19a. Informant's Name/Relationship (Type, Print) Sister In Leg Wailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Catherine M. Szimanski Edgemere, Maryland 21219 2303 Lodge Forest Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sacred Ht. of Mary Cem. 10/13/2012 Dundalk, Maryland 4 Donation 5 Other (Specify) Signatur / Funeral Service Licensee Gregory Reed Buda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tenture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition Medical resulting in death) Due to (or as a consequence of) <sup>2</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transit Cause (Disease of Injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 morns?

1 Yes 2 No
9 Unknown ate has been signed by the atter page 2 should be detached for u Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ ₩6 completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗗 № Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq'\) Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation after death 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying-Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State 2012 09

HDHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GENE Physician/ SPEED SR Month **©**\$ 12.35 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMAHITAN JATIG20H BALTIMOR N/A Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 213-46-3441 Director 1 🛛 M 2 🗆 F 66 Dec. 7, 1945 Maryland Usual Residence of Decedent other than "natural", or Itams 23a or 28a-f shov ont, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2 🏋 No Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2614 Taylor Ave. 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Secondary (0-12) permit. Page 1 and 2 should ba filed with Department of Health and Mantal Hygier Important: If item 27 is marked other than any injury or other traumatic event, the once. Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norris Thomas Freida Speed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene E. Speed, Jr./Son 2614 Taylor Ave. Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter), crematory or other place)
Dulaney Valley
Memorial Gardens Oct. Date 22. 20c. Location - City or Town, State 1 🖾 Burial 2 🗀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 er Scruice Licensee Timonium, MD 21. Signature of Fa 22. Name and Address of Facility.
Lemmon Funeral Home of Dulaney Valley. Inc.
10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death SEPTK SHOCK. Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): INFELTION Examiner STREAM BLOOD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that tha death certificate be axecutad signed by the attending physician and deaded for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ LENAL DISEASE STAGE 1 Yes 2 No 3 Probably 4 Unknown this certificata has bean sirral director, page 2 should I Completed FAILURE CONSESTIVE HEART 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) € No 2 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death. tha Funeral Director: Aftar this mpletely filled in by the funeral c 28a. Date of injury (Month, Day, 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To tha F

complet only one) 29b. Signature and title of certifie 29c. License number MD PES 000 12.UJAM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHMEEP SEHGAL 56 LOCH LAUEN BLUD. 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 9 2012 Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene For State Registrar 32345 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 5, 2012 Daniel Ray Sills Sr. 12:45 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air TOD: 1245 If Under 1 Year If Under 24 Hrs. . Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 220-46-7301 **Director** 1X M 2 □ F 65 July 25, 1947 North Carolina Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Delta York 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17314 USA 2 Valley View Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or Completed by 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mea one. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Operating Engineer Construction Danie Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mittie Blown McCloud Clyde Ray Sills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine T. Sills / Wife Valley View Road, Delta, Pennsylvania 17314 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/9/12 Rose Hill Svcs. LLC Bel Air, Maryland Sometize of Fundami Service I censee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE m 800513169 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Year Day 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed lirector, page 2 should be def 23e. Did tobacco use contribute to the cause of death? Obstructiv 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral o 28a. Date of injury (Month, Day, Year) Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after deanal Director: After 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound To the Funer completely file 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 120056296 10-5-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NESON DIRNMINM MD 5000PPER Chesapeake Dr. Bulain, Md 21014 31. Date filed (*Month*, *Day*, *Year*) **0CT 0 9 2012** 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland, Department of Health and Mental Hygiene Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32346 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Abraham E. Shapiro October Medical 05. 2012 9:30 am 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Warm Heart Assisted Living Germantown Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8 Date of Birth 9. Birthplace (State or Foreign 579-24-5587 Director (Month, Day, Year) 1 X M 2 □ F 88 ual Residence of Deceder 12/16/1923 Washington, DC 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, if the Modical Examinar must be motified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Montgomery Village 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19310 Clubhouse Road. 20886 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 🖎 Yes 2 🗌 No 1 Never Married 2 X Married ģ Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Divorced Completed WWII White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Certified Public Accountant Self Employed Be permit. Page 1 end 2 should be filed Department of Health end Mental Hy Important: If item 27 is marked oth any liviry or other traumatic even anse. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joe Shapiro Lena Aaronson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Levey - Daughter 12329 Chagall Drive. North Potomac, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 10 09/07/2012 Falls Church, Virginia 4 Doration 5 Other (Specify) Kina David Mem.Grdns. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the downse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Interval Between Onset and Death Physician/ Alzheimer's Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burlel-trensit ause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, to the Hospitel or within 24 hours To the Fire come: City or Town, State Medical 1 Medical Examiner: On the basis of examination and/or investigation in proceedings death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Contribution on the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D37142 October 05. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Coleman. 6001 Muncaster Mill Road, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month KENNETH JOHN SAMS Medical October 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 MARYLAND Social Security Number 7. Age (In vrs. last birthday) **Funeral** Director 219-28-8665 1**X** M 2 □ F 81 yrs. DECEMBER 14,1930 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if tem 27 is marked other than "netural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at ence ince. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Y Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 21214 U.S.A. 6117 Marietta Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 🗆 Yes 2 🏝 No If Yes, Give Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Pump Truck Unknown Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Blanch Feldman Unknown Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Sams 6117 Marietta Avenue Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem 10/5/2012 Overlea, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Miller-Dippel Funeral Home, Inc.
6415 Belair Road Baltimore, MD Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARPIAL Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use es the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate 1 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital c within 24 hours at To the Funeral D completely filled Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ath (Item 23a) (Type, Print) 30. Name and address of pe 10V North Charles State 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year 1:17 October РМ Hilda M. Sokol Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth Age (In vrs. last birthday) **Funeral** Days Min (Month, Day, Year) 579-20-6997 **Director** 1 □ M 2 🛚 F 89 July 17, 1923 New York Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 X Yes 2 □ No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20852 United States 1606 Martha Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural" 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker h and Mental Hygier 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Christine Dorshamet Pierre Pallamary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a 1606 Martha Terrace, Rockville, Maryland 20852 Michael D. Sokol / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date unk. 20c. Location - City or Town, State Artington
National Cemetery permit. Page 1 Department of Important: If ii any injury or or 1 X Burial 2 Cremation 3 Removal from State Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home, Rockville, In 300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signatur of Furera Servi M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 JE FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown signed by tl Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2-☐ No 3 ☐ Probably 4 ☐ Unknown been sig Keval 24b. Were autopsy findings available prior to completion of cause of has autopsy performed' death? certificate 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 10 Other: 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral ot 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending **Division** 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Medical Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00061302

DHMH 17 Rev 06-2011

State Registrar

0/05/201

8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Atul Rohatgi, M.D.

5/ 101

2012

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Physician/ 2012 Tirabassi 12:23 p<sup>M</sup> Michele Suzan October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital Rosedale Baltimore 72 If Under Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number **Funeral** (Month, Day, Year) Days Hours 216-66-4182 55 Director 1 M 2 XF Dec. 6, 1956 Maryland Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City. Town or Location ms 23a or 28a-f sho must be notified at Director Rosedale 1 🗌 Yes 2 🂢 No Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21237 Funeral United States 6101 Hamilton Avenue 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 X No Specify. Whi te 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Travel Agent/Caregiver Mental Hygiene. Service Industry Michele Tira 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Marie Elizabeth Harris Mario Paul Tirabassi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 32700 Mt. Herman Rd., Parsonsburg, Maryland 21849 Jessica Cooney / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Metro Crematory Inc. 10/08/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc Signature of Funeral Service LicenseeAlyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part 1 shock, or heart failure. List only one cause on each line. Appartensive Arterioscherote (adousses Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence on sician and burial-trans Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 4 Pregnant a 9 Unknown Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No nis certificate has t I director, page 2 s 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Yes 2 🗌 No ည 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Medical Certificate: 1 Natural 2 Accider 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Turse Practitioner: To the best of my in college, death organized tills time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, CHILD OLD 29c. License number PI State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32351 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2012 Phillip Terrel1 Medical 3:20 PM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year I If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Dav. Year) Director 577-78-9084 1 □XM 2 □ F 54 July 6, 1958 Maryland r then "neturel", or items 23e or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince George's District Heights 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3802 Cricket Avenue 20747 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 □XYes 2 □ No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. \$ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 hours efter 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Heelth and Mental Hygiene. ant. If Item 27 is marked other then 'ury or other treumetic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Government Flat Sorter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Terrel1 Wilhelmina S. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7417 Electra Court <u>Gaithersburg, MD 20879</u> Penny R. Terrell/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 10-15-2012 | Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. ) aphne 7474 Landover Road Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Distan lerot.U 1050001-Ariter Physician therosc disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ettending physician and I for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death **Director:** After this certificate hes been signed by the In by the funeral director, pege 2 should be detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🕱 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No |2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospitei or Attendii within 24 hours after death. To the Funerei Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 10/03/17 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

32. Registra

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/vette	Michelle	Tart	

State of Maryland / Department of Health and Mental Hygiene

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Physicia						-	2. Date of Dea	th	3. Time of Death
ledical Exami	ner	Yvette Michelle Tart						Month Day Year September 27, 2012 0915	
		<ol> <li>Facility Name (if not institution, give street and number 9014 Rhode Island Avenue #707</li> </ol>	)		City, Town, or		of Death	4c. County of Dea	
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Funeral Director			ge (In yrs. last bi		Months Days			th (MM/DD/YYYY) 9. B Fore	ian
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any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location	1			-	10d. Inside City Limits
<b>E</b>	_	MD Prince George's	Co11	ege Pa	rk				1 Yes 2 No
Maryland 28a-f show 1 at once.	cto	10e, Street and Number	0011		Of, Zip Code	-	1	0g. Citizen of What Co	11
215-0036 be filed within 72 hours after death with the Maryland and Hygeine. red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Director	9014 Rhode Island Place	707			207	42	USA	•
with t		11, Marital Status 12. Was Deceden	t Ever in U.S.	13. Was [	Decedent of His	spanic Orig	in? ( Specify Yes or No		rican Indian, Black,
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nours		15. Decedent's Education (Specify only highest grade co	mpleted) 16a		Usual Occupat of working life.		kind of work done	16b, Kind of Business	
5-0036 led within 72 hou Hygiene. other than "and the Medical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or	5+)	daring into	or working me.	. 501101	ass rollings,		
15-0036 filed within 72 I Hygiene. dother than "	E	9 0		sales	associ		- Name (First Middle A		
filed Hyger of the	BeC	William Joseph Cousin Jr					s Name (First, Middle, M	,	
Z = 2 = 3	B	19a. Informant's Name/Relationship (Type, Print)		9b. Mailing A	ddress (Stree		an Marie Co beror Rural Route Num		e. Zip Code)
O de la a		Jean Myles/mother	21				ace Upper M		
ore, MI ss 1 and 2 s of Health a If item 27 her traum		20a. Method of Disposition			n (Name of cer		Date	20c. Location - City of	
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funer   Service Licen   de/, Dir		22. Nan	ne and Address	of Facility	oard 655 W.		
E F G R		Similar Co. Dil	ector	Ralt	imore	omy B	oard 655 W.	. Baltimore	Street
Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do r	ot enter the	mode of dying,	such as ca	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Doxepin I	ntoxica	tion					Death
_Au		or condition resulting in death)  Due to (or as a cons	equence of):						
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	Examiner	cause. Enter Underlying Cause (Disease or injury triat initiated c.							
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30x 68760, death certificate be to attending physici I for use as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outco		_	death 3	Ectopic	pregnancy	23d. Date of delive Month	ry Day Year
Box 687 e death certific the attending ped for use as the	Sicia	4 Pregnant a	t time of death		(Specify)				
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s, P.O. Box hires that the death signed by the atte d be detached for u	by F	Part II. Other significant conditions contributing to dear	h but not resultii	ng in the und	erlying cause g	iven in Pai		bacco use contribute to	bably 4 V Unknown
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Rec The I	Completed						1 ✓ Yes		es 2 No
Division of Vital Records, and a Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	å	25. Was case referred to medical examiner? [Hospital: 4 ] hospital				Othor -	Check only one)		
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Hospi 24 hou Funer rely fil		29a. Certifier (Check only 1 Certifying Physician: To the best of n			at the time, da	ite and pla			
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) 2 Medical Examiner: On the basis of exa							
F 3 F 8	Me	29b. Signature and title of certifier			29c, License	e number		29d. Date signed (Me	onth, Day, Year)
		( ) Gratuland )			O.C.I	M.E.		September 28,	2012
		30. Name and address of person who completed cause of			1				
		Laron Locke MD. Assistant Medical Ex		0 W. Balti	more Street	t, Baltim	ore, MD 21223		
St Regist		31. Date filed (Month, Day, Year)  32. Registra	ar's Signature	hay	1.1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 2°012 11:00am Van Nguyen Tho Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 220-33-6342 1 X M 2 □ F Director 82 10/19/1929 Vietnam er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Silver Spring Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20904 14210 Cape May Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes. Give Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Petroleum Company Senior Craftsman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bong Thi Huynh ဂ Quy Van Nguyen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14210 Cape May Road, Silver Spring, Maryland 20904 Thach Ngoc Nguyen - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Baltimone Chematory at Loudon Park 1 🔲 Burial 2 💢 Cremation 3 🗍 Removal from State 10/08/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Respiratory Failure Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Weeks Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Hupothyroidism 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Chronic Kidney Disease autonsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medica Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 28b. Time of 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 8c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending s after death.

I Director: Al Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 124 hours af • Funeral Di letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Funel completely fi 2 L Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 04, 2012 D32332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 Suresh K. Gupta,

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dolores McClennon Wills 2012 0:30 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Town, or Location of Death 2936 Har Baltimor Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 168-24-1617 1 M 2 DE 81 Months Min. Days Hours 1 1<sup>M</sup>2<sup>n</sup>5<sup>n</sup>4<sup>n</sup>9<sup>n</sup>3 0 Pennsylvania **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 921 Sun Circle Way 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 □KWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry
Eagleville Rehab 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Hospital vears Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanley McClennon Dorothy Catagnus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaVon Bratten(Daughter) 921 Sun Circle Way, Baltimore, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1  $\square$  Burial 2  $\overline{\mathbf{X}}$  Cremation 3  $\square$  Removal from State on-site Crematory/0/05/10 4 ☐ Donation 5 ☐ Other (Specify) |Baltimore, MD of Funeral Service Licenses 22. Josephres Hif FBrown Jr. Funeral Home PA u 2140 N FUlton Ave., BAltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Death Immediate Cause (Final Ph sician/ disease or condition 200 Medical resulting in death) Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy performed 2 🗌 No ☐ Yes 25. Was case referred to medical director, 쏊 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Assisted 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1- Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) B'More STERN

State

Registrar

31. Date filed (Mont)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) G 23 AM Physician/ atricia Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) Baltimore Hospita Hopkins Johns 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. **Funeral** Country) 218.42.5784 1 🗆 M 2 💢 F **Director** 1941 01 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director Battimore Yes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number US.A Funeral Avenue Apt. Towanda Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonce. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Goucher College Cook NIA 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lila Cook Raymond Chambers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 315 Norgulf Road Keisterstown MD 21136 Tracey Bordley Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State COOKSVITE MD Park Cemetery 10/12/2012 Bushy 4 Donation 5 Other (Specify) Vougho C. Greene Funoru Services 22. Name and Address cility 21. Signature of Funeral Service Licensee Liberty Road Planda Ustown MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shon as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final metastic adeno carci Ph\_sician/ once ( disease or condition resulting in death) Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carrying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examine the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 4 Pregnant 5 Other (specify) signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nnknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? 2**X**No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred iniury 5 Pending Investigation Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signatur

Registrar

State

orleans St Baltimore

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completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day C7 Year Physician/ 63:37 AM ea Therso 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital Sinai of Ballmore Baltmore If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9 Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 428-78-5397 1 MM 2 □ F Director MI 0-26-1939 weath erslay Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 ☑ No Town 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number Funeral 21/33 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 Specify: 3/ack 1 ☐ Yes 2 ☑ No Specify. permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exer If Yes. Give Lusher 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of Nife. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) extired larine B 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) licia Kanci 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) parrison C. Greene Fineral Gervice Ranchallstown, MD 21133 Eneral Gervices 22. Name and Address of Facility Vauchn 21. Signature of Funeral/Service Licensee an 23a. Part 1. Ent che disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pneum one .Physician/ Ventilator - associated disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by status-post trachoostomy respirator 2 No 3 Probably 4 🗷 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an brain autopsy within 24 hours after death.

To the Funeral Director: After this certificate has completely filled In by the funeral director, page 2 sempletely filled In by the funeral director, page 2 sempletely filled In by the funeral director. renal distass 1 Yes 2 XNo End-stage 1 TYes 25. Was case referr to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No မ 1 KInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) .2012 MBBS 000 ०न October 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinou NAMITA SMUH Hospital Bellhmore MBBS 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Clark John Wagner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 226-52-6449 Director 1 M 2 F 10/3/1941 VA end Mental Hygiene. Is marked other then "neturel", or items 23e or 28e-f show reumetic event, the Mydicel Examinar must be notified at 10d Inside City Limits 10b. County 10c. City. Town or Location Director 1 🗌 Yes 2 🖪 No Westminster Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21158 1244 Weller Way 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 N Married 1 Yes If Yes, Give δ Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer Government Be 18. Mother's Name (First, Middle, Maiden Surname)
Martha Scott 17. Father's Name (First, Middle, Last) of Health end Mental of Health end Mental fitem 27 is marked rother treumetic ev ဂ္ A. Henry Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1244 Weller Way, Westminster, MD 21158 Cynthia Hirshberg-wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 e Department of H Importent: If Ite eny Injury or ot 1 Burial 2 Cremation 3 Removal from State South Carroll Crem 10/6/12 Winfield 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of FacilityFletcher Funeral Works 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4NOXIC Physician Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine PIRATION The law requires that the death certificate be executed physician end sthe buriel-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use es attending for use es IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown 1 Yes Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has 1 ☐ Yes 2 ☐ No certificate Yes 2 No Hospital or Attending Physicien: 24 hours after death. 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA <u>မ</u> erei Director; After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No Natural Accident 5 Pending Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOUND KIND WORKL AVE, WETTM WSTER, MD ZHIE

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Walter West Month  $201^{
m Yea}$ 4:29 a October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Westminster Carroll Hospice Dove House 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Director 212-38-0856 1 X M 2 □ F 72 MD 1940 June 16 Usual Residence of Deced or then "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Sykesville MD Carroll 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 Funeral 7612 Schoolhouse Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) backhoe operator other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Heelth end Mental H fitem 27 Is marked ot ၉ Stanley West Esther Savoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Edgar West (brother) <u>3723 Courtleigh Dr., Randallstown, MD 21133</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Importent: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Sykesville, MD White Rock Cemetery 10-12-12 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Saught Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Medical Certificate: To 2 👿 Inpatient 1 🗌 Yes 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 🗌 Pending 1 🗀 Yes 2 🗌 No Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11,15, Share by Warvand 9 as ep anne hi of Heart and Menia 1960 he 2012 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 08:34 AM 28, September 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) 6. Sex Days unk 230-80-7800 Mar 4, Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 No Baltimore MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 21206 USA 5009 Frankford Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No U 14. Race - American Indian, 1 Never Married 2 XX arried 1 ☐ Yes 2 No If Yes, Give white 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Rehab. Counselor Shephard Pratt Hosp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Styles Joseph Styles 19a. Interprete Name / Relation / Caughter Hopking Bayview Hospital 19b. Mailing Address (Street and Number or Gural Boute Number, City or Town State 7 in Social 4 TU2\_Cutty Shark RD\_Middle River, MD, 21,220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bayview Crem. 10/11/2012 Baltimore, Md 4 Donation Specify) 21. Sign tupe of Funeral Service Lice de 22. Name and Address of Facility Hari p. Close Fun. Ser. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as Honsequence of):

**Physician** /Medical Examiner

other t

Department of F Important: If ite any injury or ott once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Funeral

Completed by

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

ate has been signed by the average 2 should be detached to

ulcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	function			
I ysiciali / Ivie	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		tate of delivery fonth Day Year	
elen na .	Part II. Other significant conditions con  End Stage Lewal	1 Yes 2 No				
				autopsy performed?  1 Yes 2 No	prior to completion of cause of death?  1  Yes 2 No	
D	25. Was case referred to medical		26. Place of Death	h (Check only one)		
2	examiner? 1  Yes 2 No	lospital: 1 Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing Ho	me 5 Residence 6 0	ther (Specify)	
TIOII.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurred		
Sillia.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, stre building, etc. (Spec/fy)	eet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
בפוני		sician: To the best of my knowledge, death ner: On the basis of examination and/or in				

29c, License number

DD 000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 6 Day 2012 ar Physician/ 8:00 A M ROSE WILDER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY KENSINGTON PARK KENSTNGTON If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday **Funeral** Months Hours 065-12-8882 1 □ M 2 🗓 F **Director** Yrs 05/21/1921 NY 91 show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State notified at Director 1 Yes 2 X No 28a-f MONTGOMERY KENSINGTON MD the ! 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö ms 23a or must be r with t Funeral 20895 USA 3620 LITTLE DALE ROAD items Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Examiner Black, White, etc. Ь þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. WHITE 1 ☐ Yes 2 X No Specify. If Yes, Give Specify. "natural", Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than ntal Hygiene. ed other than event, the N Elementary/Secondary (0-12) College (1-4 or 5+) ASSISTANT TOY BUYER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H
27 is marked of ပ DORENFELD TOBE LOUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9521 SWEET GRASS RIDGE COLUMBIA, MD 21046 JAY WILDER / SON Department of Health Important: If item 27 any injury or other to once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 X Removal from State 10/12/2012 S.W. RANCHES, FL MENORAH GARDENS 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fupera Service Licenses PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in freductions cause. Enter Underlying Examine Date to for as a constraint on off Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year Other (specify) Pregnant at time of death the : Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has s certificate has director, page 2 performe 1 ☐ Yes 2 🗓 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tyes 2 🗓 No 4X Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending within 24 hours after deam.

To the Funeral Director; After the funeral part of the fu 2 🗆 No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of co 29d. Date signed (Month, Day, Year) D26259 10/6/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 WISCONSIN AVE. BETHESDA, MD 20814 AVA KAUFMAN, MD 31. Date filed (Month, Day, Year, 32. Registrar's Pignature State 0 9 2012 Registrar

chael Eugene	Wh	ite State 1- For State	or Print in Bia e of Maryland /	Depa		of Health ar			J	201	2 3236
Physicia	n/	Registrar  1. Decedent's Name (First, Middle,La	ast)		rimeate c	- Dealit		2. Date of	Reg. No.	201	3. Time of Death
edical Examir		Michael Eugene	White						Day mber 29,	Year 2012	2041 hrs
		4a. Facility Name (if not institution, g	ive street and number)			4b. City, Town, o	or Location of D		4c	. County of Death	
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any		Usual Residence of Decedent  10a. State 10b. County	1	0c. City	, Town or Loca	ation		<del></del>			10d. Inside City Limits
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after al", c	3		ed If Yes, Give Year		1	Yes 2 X No	o specify:			Specify: Bla	ck
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212 Duld b Meni mark	2	19a. Informant's Name/Relationship	Type, Print )		19b. Mailir	ng Address (Stre	Janet et and Number		pencer Number, Ci		, Zip Code)
MD 12 shc th and 27 is		Ebony Goodwin/Da	ughter			East Pla					
Fe land Heal		20a. Method of Disposition  1 Burial 2 X Cremation 3			Place of Dispo	sition (Name of ce	emetery,	Date		Location - City or	Town, State
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.	П	4 Donation 5 Other Specif		1		cremato	ry 1	0_00_20	12 Pi	iwardala	, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	П	21. Signature of Funeral Service Lice		1111	22.	Name and Addres	s of Facility J	.B. Jen	kins E	uneral	Home, Inc.
<b>™</b> 50 € 00	М	( John	202		31	7474 La	indover	Road,	Hyatts	sville,	MD 20785
Physician /Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused the	e death	. Do not enter	the mode of dying	, such as card	iac or respirator	y arrest, sho	ck, or heart	Approximate Interval Between Onset and
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Box 68760, and death certificate be the attending physicate for use as the burned for us	Physician/Me	1 Yes 2 No 9 Unknow	7	ne or	5 C	ther (Specify)					
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Division Hospital or Attence 24 hours after death Funeral Director:		4 Homicide determine	(opeony) The					Suitl	and Ro	oad Sui	tland,MD.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bun	Medical	(Check only   Certifying Physic	cian: To the best of my ler:On the basis of examin	nowled	ge, death occu nd/or investiga	arred at the time, d	iate and place, n. death occurr	and due to the	cause(s) and	manner as state	ed e cause(s)
To the within To the comple	₩.	29b. Signature and title of certifier	and manner stated			29c. Licens				Date signed (Mor	
		Ou ST				O.C.				tember 30, 20	
	-	30. Name and address of person who	completed cause of des	th (Item	23a)						- · · -
		Ana Rubio M.D., Ph. D.	Assistant Medica		•	) W. Baltimore	e Street, Ba	altimore, <b>M</b> E	21223		
Sta		31. Date filed (Month, Day, Year)	3 Registrar's	Signatu	ire						
Registr	ar	OCT 0 9 2012	Brun	A.	Sau	2					
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21. Lawrence Oliver Whaley September 4:45  $AM^M$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 1546 Belvedere Road Port Deposit Ceci1 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 110 k 8. Date of Birth (Month, Day, Year) **Funeral** Months Min 214-46-7903 1 XM 2 □ F **Director** July 8, 1947 Usual Residence of Decedent 65 items 23a or 28a-f show ler must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Port Deposit MD 10e. Street and Number Cecil 10g. Citizen of What Country? Funeral 1546 Belvedere Road 21904 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or itel Was Decedent Ever Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 【 No Specify. Completed 3 Widowed 4 Divorced white Medical unk Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the unk unk and Mental Hygier is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gladys Janett Singleton Ulysses Oliver Whaley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code item 27 i 1546 Belvedere Road Port Deposit, MD Laura Lablanc/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Important: If it any injury or o once. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Ronald 8. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Wade, Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Pulmonary Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home e Hospital or Attending Phys n 24 hours after death. e Funeral Director: After this pletely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

30. Name and address of person

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31. Date filed (Month, Da

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who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Smonth Physician/ Day Donna L. Weisner 10:30 AM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St- Agres Hospital Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min. Director 219-50-5205 1 □ M 2 💢 F 63 Yrs. Oct 23, Maryland or 28a-f show filed within 72 hours after death with the Maryland 10a, State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1205 Dorchester Avenue 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 0 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 X No 1 ☐ Yes 2 🔀 No Specify: "natural", If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Secondary (0-12) secretary legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellwood Leroy Brown Sr Mildred Anna Brayden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna E. Brown/sister in law 3525 Lakeway Drive Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Eunera Service Licensee, RONALd S. Made Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street in Raltimore, 21201 MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician, Atherosclarota Heart rears Medical Due to (or as a consequence of): Examiner Morbid Obesity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Examine Due to (or as a consequence of) The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Mellitus 415 sabetes Due to (or as a consequence of): Physician/Medical cars tension P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hypercholesterolemia 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' Director: After this certificate Yes 2 No Division of Vital Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Hospital 2 🔀 No Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 11 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi

State Registrar DHMH 17 Rev 06-2011 oseph

31. Date filed (Month, Day, Year)

Agnes Hospital

Back

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and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D46505

900 Caton Ave.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<sup>Day</sup> October 2012<sup>Year</sup> Physician/ 4:10 PM M Mary Jane Weidman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1007 Dellwood Drive Fallston If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Days Min (Month, Day, Year) Director 219-44-5641 1 🗌 M 2 🗓 F July 3, 1946 Marvland 66 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No Fallston MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21047 1007 Dellwood Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) industrial administrative assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Evelyn Sylvia Royahn Tracey ပ John Melvin Diehl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Dellwood Drive Fallston, MD Wm F. Weidman III/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Omps Crematory or other placel Omps Cremation Center 1600 Amherst Street 1 Burial 2 X Cremation 3 Removal from State Winchester, VA 22601 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Vice ade, Director 225 Pantal Address Back Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pact 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brea Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Wospice 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29c. License number 29b. 29d, Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

legistrar's Signatu

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of M	laryland /	-	rtment of H ificate of D		nd Mer	ntal Hyg	iene	112	32366	
			Registrar  1. Decedent's Name (First, Middle, L	.ast)			mouto or B	- Outil		Date of Deat	th		3. Time of Death	
	Physicia Medic		Charles J. Wade September 27, 2012									10:10 PM		
	Examin		4a. Facility Name (if not institution, go Kline House Ho			Ì	4b. City, Town, or Mt. Air		Death			ty of Death derick		
	Funeral			. Sex 7. A	If Under 1 Year	If Under 24	4 Hrs. 8. I	Date of Birth			lace (State or Foreign			
	Director		230-42-2157	1 🌠 M 2 🗆 F	75	Yrs.	Months Days	Hours		Month, Day,		Ohic	"	
	and show	ō	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loca	ation		12-0	,, <u>, , , , , , , , , , , , , , , , , ,</u>			0d. Inside City Limits	
	Maryl 28a-f otified	Director	MD Jeffers	on	Fr	ederi							1 Yes 2x No	
	ith the		10e. Street and Number 4320 Teen Barne	a Dood			10f. Zip Code 2175	E			10g. Citizen o	f What Coun ISA	try?	
	eath w	Funeral	11. Marital Status	12. Was Decedent		13. W	as Decedent of Hi	spanic Origin	n? (Specify	Yes or No-	14. R	ace - Americ		
36	after de ", or it amine		1 Never Married 2 X Married	Armed Forces  d 1 Yes 2 If Yes, Give			Yes, specify Cubar □ Yes 2 🙀 No		Puerto nica	Black, White, etc.  Specify: white				
9	nours a	etec	3 Widowed 4 Divorced  15. Decedent's		1	6a. Decede	ent's Usual Occupa	ation		Т	1	Business/Inc		
215	iin 72 l ie. han "r e Medi	Completed by	(Specify only highest Elementary/Secondary (0-12)	College (1-4 or	5+)	life. DO	nd of work done d NOT use retired)			!				
Maryland 21215-0036	ed with Hygier other t	Be C	12 17. Father's Name (First, Middle, Las	2		fede	ral inve			rst. Middle, I	go Maiden Surna	wt me)		
an	l be file fental rked c	욘	Jack Richard							Grau				
lary	should be filed on and Mental Hyg 7 is marked other raumatic event.		19a. Informant's Name/Relationship	(Type, Print)			g Address (Street a					, State, Zip C	code)	
	and 2 Health em 27 ther to		Virginia Wade/s	pouse			Teen Barr	nes Ro	ad Je			2175 n - City or To		
ш	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 4 🎇 Donation 5 ☐ Other (Spe				atory or other plac	e)	Date			,	,	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signat e of Runaral S raice sic		ector		Name and Address			655 W	. Balt	imore	Street	
Н			23a. Part Enter the disease, or conshock, or heart failure. List only	omplications that caus	ed the death. D	IBA o not enter	ltimore, the mode of dying	g, such as ca	ardiac or res	spiratory arre	est,		Approximate Interval Between	
	Physician/	39 V	Immediate Cause (Final disease or condition	. Nex	uro€	ind	OCTIO	ea	anc	'er			Onset and Death	
	Medical Examiner	resulting in death)  Due to (or as a consequence of):												
	418	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter or indexlying											
	cuted and transit	Examiner	Cause (Disease or injury that initiated events	C. Duo to (or s	s a consequenc	ce off:		<u></u>						
0	be exe sician a burial	dical E	resulting in death) Last	d d	o a concequent	50 01):								
68760	ificate ng phy	Medi	IF FEMALE:	_ u								1500		
Box 6	ath cert attendii for use	cian/	23b. Was decedent pregnant in the past 12 months?			eath 3 🗀	Ectopic pregnand Other (specify)	:y				Date of delive Month	ery Day Year	
ŏ.	the deg	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗌 Unknow	n									
, P.O.	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Me	Part II. Other significant conditions	s contributing to death	but not resulti	ng in the ur	nderlying cause giv	en in Part I.			bacco use co res 2 🗆 No		ne cause of death?	
ords	require been s should	letec							_	24a. Was a		b. Were auto	osy findings available	
Sec Sec	rsician: The law I s certificate has b director, page 2 s	dwo								autop perfor 1 \(\supersection\) Yes	med2	prior to co death? 1 \(\superstack \text{Yes}\)	mpletion of cause of	
æ	Physician: T this certifica eral director, p	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death	n (Check onl					
Ž	Physic r this c eral dir	ان ا	1 Yes 2 No 27. Manner of Death	1 ☐ Inpa		b. Time of	t 3 DOA Othe	4 LI Nur		5 Resid	ence 6 Co	ther (Specify urred	HOSPICE	
ouo	ath. r: Afte	licate	1 Natural 5 Pending 2 Accident Investiga	ation	Day, Year)	injury	M 1 🗆	? Yes 2 🗆 N	No					
Division of Vital Records,	l or Atte after de Directo d in by ti	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of I	njury - At home etc. <i>(Sp</i> ec <i>ify)</i>	, farm, stre	et, factory, office		28f.	Location (S City or Tow	treet and Nur n, State)	nber or Rural	Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	(Check 2 Medical Ex	Physician: To the best aminer: On the basis o	f examination ar	nd/or invest	igation, in my opinio	on, death occ	curred at the	time, date a	nd place, and	due to the ca	use(s) and manner stated.	
	Fo the	Ž	only one) 3 L Certifying N 29b. Signature and title of certifier	Nurse Practitioner: To	the best of my	knowledge,	29c. License		e and place,		ne cause(s) an 29d. Date <b>a</b> ig			
			1 Erep	Such	MD.		De	58KC	)4		9/0	18/2	2012	
			30. Name and address of person wi	5h MD	f death (Item 23	Ba) (Type, P	ailA.	VP, Y	Fra	der	ick.	m	21702	
	Sta Registr		31. Date filed (Month, Day, Year) QCT 0 9 20	012 , S2. Regis	trar's Sign ture	par	de l							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Raymond Wentworth State of Maryland / Department of Health and Mental Hygiene 2012 32367 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Year October 4, 2012 0205 hrs Raymond Lewis Wentworth Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital **Baltimore County** 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY **Funeral** Foreign Maryland 215-42-6462 Months Davs Hours Min Director 69 Oct. 23,1942 1 XM 2 F Usual Residence of Decedent 40 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 Xio 28a-f show MD Baltimore Parkville hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8833 Baker Avenue 21234 USA or items 23a 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2 X No 1 Yes White 4 Divorced f Yes, Give Year 1 Yes 2 X No specify: Specify: 3 Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "". College (1-4 or 5+) Post Office Letter Carrier the Medical 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Christopher John Schoilian Catherine Elizabeth Ruppert Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Wentworth-spouse 8833 Baker Avenue-Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State Date crematory or other place)
Evans Funeral Chapel 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland Oct.6,2012 and Cremation Ser Belair 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licenses Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 ME Fred 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Complications of Amlodipine and Atenolol Toxicity Between Onset and /Middlichi a complicating Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical the attending physician ed for use as the burial -X UNPENDED AMENDED 23a, 27, 28a-f, per me, g932 10-31-12 smThe law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown this certificate has been signed by the att al director, page 2 should be detached for Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed Yes 2 ✔ No 2 No To the Hospital or Atteodiog Physiciao: 'within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other Inpatient 2 FR/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Intentional ingestion o prescription medication 1 Natural within 24 hours after death.

To the Fuoeral Director: A Division 5 Pending 1 Yes 2 X No fd 10-2-12 fd 18:39 pm 28e. Place of Injury - At home, farm, street, fac ory, office building, etc. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8833 Baker Ave. Parkville, MD. 3 X Suicide 6 Could not be determined (Specify) Single Family Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number OCME October 5, 2012 of 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Mildred Wiggins E. 2012 Medical October 08 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Health & Rehab Anne Arundel Glen Burnie . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth March 25 1926 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 220-22-9473 Country) Director 1 🗆 M 2 💢 F 86 Usual Residence of Decedent show 10b. County 10a, State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🌠 Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21231 603 S. Ann Street, Apt. 202 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. 1 Never Married 2 Married ۾ Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Baker H&S Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Trapp Anne E. Albright Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 16 Patapsco Road, Linthicum, MD 21090 Elwood G. Trapp Sr. (brother Baltimore, 20a. Method of Disposition Date 12 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jessop Church Cemeter Sparks, Maryland 2012 21. Signature of Funeral Service Licenses 2. Name and Address of Facility Stallings Funeral Home, P.A 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death D not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between STROKE Immediate Cause (Final HEMORRHAGIC Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should After this certificate has been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

**OCT 0** 9 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R 'S DHARMASENR, M-D . 3721 POTCE St. BALTIMORE, MD 21221

EUM WED.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1_ For	State of Maryland	/ Departm	nent of H	ealth and l	-	_	32369		
			Registrar  1. Decedent's Name (First, Middle, Last)	)	Certific	cate of l	Jeath	2. Date of Dear		3. Time of Death		
	Physici /Medic			itkins				October	6 2012	0337 AM		
	Examin	er	4a. Facility Name (If not institution, give Boy Secures H	street and number)	4b.		MULE	City	4c. County of Dea			
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. las		Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth		thplace (State or Foreign ountry) VA		
	Director		215-22-8750 Usual Residence of Decedent	<sup>1M 2⊠F</sup> 105	Yrs.	nths Days	Hours Min.	8. Date of Birth (Month, Day 01-04-0	99			
Marylan	f show	ō	10a. State 10b. County NA		Fown or Location LMOTE	1				10d. Inside City Limits 11 Yes 2 □ No		
ith the	or 28a	Funeral Director	10e. Street and Number		10	f. Zip Code	17	1	0g. Citizen of What C	ountry?		
eath v	ns 23g	eral	1930 W. LaFayett		13. Was [	212 Decedent of Hi		pecify Yes or No-	USA 14. Race - Am	erican Indian,		
ING 21215-0036 be filed within 72 hours after death with the Maryland	ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, I're Medical Evantinet must be notified at	by Fun	1 Never Married 2 Married 3 Swidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		specify Cuba	n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, Whi	e, etc. African		
Maryland 21215-0036 d 2 should be filed within 72 hours af	ie. Ian "natur Medical	Completed by	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's (Give kind life. DO N	Usual Occupa of work done o OT use retired	during most of wor	rking	16b. Kind of Business			
N peg	Hygien other th	Cor	12th Grade  17. Father's Name (First, Middle, Last)	2yrs.	l	Domesti		ne (First, Middle, i	Housekeer	oing		
and pe		To Be		Tiggle			Monia		Tiggle			
Taryla 2 should	and Menta Is marked aumatic ev	-	19a. Informant's Name/Relationship (T)	rpe, Print) Grand	-			ıral Route Numbei	City or Town, State,			
	of Health and Meritem 27 Is marker other traumatic		Alice Watkins-Amb		2507 A		ngton Ci		idsor Mill,	MD. 21244		
S 8	0		20a. Method of Disposition  1 A Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State	etery, crematory Nationa	or other place.	10-1	L1-12	Laurel, N			
<b>Balti</b>	Department important: If any injury or once.		21. Signature of Funeral Service Licens	e .					ral Home I	P.A. Vland 21217		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused the death.	1					Approximate Interval Between		
	ysician		Immediate Cause (Final disease or condition	+tWerrar	cero	tic	Hen.	rt Di.	reare	Onset and Death		
	Medical caminer		resulting in death)	Due to (or as a consequen	nce of):							
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/bU, e be executed	ysician and ne burial-transit		that initiated events resulting in death) Last	Due to (or as a consequen	nce of):							
9	physic the bu	dical		d								
death cert	by the attending physi itached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of de Month	livery Day Year							
Ords, P.O	ned by e detac	by Ph	Part II. Other significant conditions co.	ntributing to death but not resulting	ng in the underly	ring cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?		
ecord: law require	s been signed b should be deta							1 🗆 Y	es 2.00 № 3 □ P	robably 4 Dunknown		
I Mec	ate has	Completed						24a. Was a autops perform	med? prior to death?	utopsy findings available completion of cause of		
OT VITAL Physician: T	is certificate director, pag	o Be	25. Was case referred to medical examiner?	Ho <i>s</i> pital: 1 ☐ Inpatient 2 💵	Outpatient 3f	Othe	ar.	ath (Check only or	ence 6 □Other (Spe	noife)		
or g Phy	- <del>-</del> - <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del>	$\vdash$	27. Manne of Death		Bb. Time of Injury	DOA 28c. Injury	4   Nursing F		ow injury occurred	icity)		
SIO	eath. or: Af the fur	catio	1'		N	10,	Yes 2 □ No					
UIVISION tal or Attending	s after death. al Director: After ed in by the funera	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fa	actory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
e Hospil	within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier N Certifying Phy (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occi n and/or investig	urred at the tim ation, in my op	ne, date and place pinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)		
To th	withir To th comp	ĕ	29b. Signature and title of certifier	^		29c. License	number	2	9d. Date signed (Mon	th, Day, Year)		
			Naulu K	Dr. mo		N58	771	C	Ctiber (	2012		
					_ \				_ 0	1		
			30. Name and address of person who co				2000 W	Baltimos	re Street	21223		

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 15:15 M Walker October Gwendolyn 2012 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs.

Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 8 28 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 K F 219-05-5739 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 21 No Director Fort Howard Baltimore 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 9120 Todd Avenue United States 21052 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: \$ 3 ℃ Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Housewife 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred J. Smith Rose Rush ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9114 Avenue C Sparrows Pt., MD Diane R. Walker (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ty∷ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mem. Park Cem10/10/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Duda-Ruck Funeral Home of Dundalk 222 Wise Ave. Dundalk, MD 21222 2007 Ave. Dundalk, MD 21222 21. Signature of Funeral Service Licensee Justin Jones 23a. Part 1. Enter the disease, or control ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory ailune **Physician** disease or condition resulting in death) /Medical Examiner prented Bay ( Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical The law requires that the death certificate be use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🔁 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes 1 Yes 2 🗌 No Division of Vital Il or Attending Physician: safter death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 No 1 🗌 Yes 2 ER/Outpatient 3 🗆 DOA ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury М 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 Thomicide City or Town, State) To the Hospital within 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only Z hadical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

aeem

31. Date filed (Month, Day, Year)

29c. License number

Res - 000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

and manner stated

32. Registrar's Signature

park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2&3 Per PHY G933 11/02/2012 VT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical ,2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death c. County of Death Cecil County 410 Delaware Avenue Elkton Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-26-7121 Months Days Hours Min March Day (Jear) 1928 Mary land Director 1 □ M 2 🔀 F 84 Page 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health end Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Exercities must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Cecil County Elkton 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21921 410 Delaware Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۾ 21215-0036 white 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen M. Murray ည Anthony B. Heine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Wilhelm 410 Delaware Avenue Elkton, Maryland 21921 husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Depertment of Important: if it any injury or o 1 Burial 2 Cremation 3 Removal from State Metro Crematory or other Oct 6, 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FaMixtchell-Wiedefeld Funeral none, Inc. 21. Signature of Funeral Se 6500 York Road Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) ii or Attending Physician: The law requires thet the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and din by the funeat director, page 2 should be detached for use as the burlia-transit din by the funeat director, page 2 should be detached for use as the burlia-transit signed by the attending physicien and id be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 🗌 Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 9 Residence 6 Other (Specify) 2 NO No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Many of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and addre

31. Date filed (Month, Day, Year)

0 9 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nelson Ching-Nee Yen 4:15 P. M October 04, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore County Towson 5. Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours Min (Month, Day, Year) 393-70-4894 Director 92 1 X M 2 🗆 F March 26,1920 Shanghai, China Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8337 Tally Ho Road 21093 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 5 1 Never Married 2 Married þ altimore, Maryland 21215-0036 Chinese 1 ☐ Yes 2 Ken Specify: If Yes, Give Year or Dates Specify: "natural" Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Residential and Elementary/Secondary (0-12) College (1-4 or 5+) Commerical Architect 04 Architect other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h မ Jing-Kwan Yen Lee-Hsi Chow Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Mrs. Maureen T. (nee Chiao) Yen 8337 Tally Ho Road Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford County) Forest Hill, Maryland Date rate function Services, Inc. ₽ = 1 Burial 2 Command 3 Removal from State ò Sunday Department of Important: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Oct. 07, 2012 License Jeffrey L.Gair, Sr. OF \$12 Name and Address of Facility Lives Funeral and Cremation Center Signatur Un Lic. #100677 2325 York Road Timonium, Maryland 21093-2215 Part 1. Erke the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Priysician/ PNEUMMIS Aspiration disease or condition resulting in death) aus ( Medical Due to or as a consequence of): Examiner ement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit After this certificate has been signed by the attending physician end if funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery ☐ Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 🗆 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE မ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my onlines, death occurred at the time. Medical 29a. Certifier (Check 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 2012 of person who completed cause of death (Item 23a) (Type, Print) N. Chance Towsow MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 9 2012 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 30 A M 2. Date of Death Physician/ OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Burnie Baltimore Washington Medical Center ANNE Alunde If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Days Min. (Month, Day, Year) Hours 214-50-2624 Director 1 □ M 2 🖾 F Maryland 23,1946 65 permit. Page 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it we Merical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21144 U.S.A. 1105 Scotch Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Customer Service Representative Grace Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Schneider Haze1 Lon Wickline Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra A. Wolfe (Daughter) 1105 Scotch Court Severn Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State KARU Date 1 ☐ Burial 2 ٌ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Atlantic Cremation 10/07/2012 4 Donation 5 Other (Specify) Glen Burnie, Maryland . Signatur of Funeral S vice Lie 22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasaden, Maryland 21122 23a. Part 1. Enter the disease, or confidence that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, 0 disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death g Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2, No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 28a. Date of injury
(Month, Day, Year)

| Description | Description | Property | Description | Property | Description | Property | Description | Property | Description | 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at 1 Natural
2 Accident 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) My 1az t 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

SAAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 32374 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2110 M -immerman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Hospital Randallstown 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days **Director** 219-16-8259 1 🗆 M 2 🛛 F Feb 5, 1925 Virginia 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Randallstown 1 Yes 27 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 26 Horseman Court 21133 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? è 1 ☐ Never Married 2 ☐ Married Black, White, etc. Completed by 1 ☐ Yes 2 ☐ No If Yes, Give X 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I and 2 should re filed within 72 f Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) entertainment Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) ం 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Horseman Court Randallstown, MD 21133 Loretta Bussie/friend permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☒ Other (Specify) in state 21. Signature of Euroral Service Licensee Ronald S / Wale, 22. Name and Address of Facility Ronald S State Anatomy Board 655 W. Baltimore Street Baltimore, MD 2120) 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ subdural hemorrhoge disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any leading to intriedit cause. Enter Underlying Due to for as a consequence of attending physician and I for use as the burial-transit Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnt 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been siy completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy
performed?

Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 | No Other: ဍ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 , Natural 5 Pending 2 Accident
3 Suicide
4 Homicide UNKNOWN Investigation unknown 1 Tes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State) 7 6 Hourse was Randolstewn Mb 211361 determined building, etc. (Specify) assistedly tac.l Medical Certifying Physician: To the best of my knowledge, death occurred at the me, date and plane, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MS RajapahlMD 30057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N SZO3 Baltimore MD ZIZOG NSRajapakseMD 2835 Smith 31. Date filed (Month, Day, Year) State Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ernest Willie Bennett don't. Pay 20 Yez 5:45 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 3543 Lineboro Rd. Manchester Carroll 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours 259-50-8529 1 🛚 M 2 🗆 F Apri Pay, 24, 1981 corporgia **Director** 81 Usual Residence of Decedent 28a-f shov at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified Maryland Carroll Manchester 1 Yes 2 X 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 3543 Lineboro Rd. 21102 U.S.A. death v 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?

1 XYes 2 No or þ Black, White, etc. 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 Divorced 1953 Signatura 1953 Specify: White Completed Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.

7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) the Mechanical Worker Union Special Con Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 1 and 2 should be of Health and Menta Gilford Marion Bennett Arvie Lou Greenway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 i Dolores Bennett - wife 3543 Lineboro Rd. Manchester, MD. 21102 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Department Important: If any injury or Oxford Cem. Oct. 11,2012 Oxford, PA. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Sail 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** EARS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months? Pregnant at time of death Month 2 No the 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by y per chalestera Com Completed 2 No 3 Probably 4 Unknown Yes peen CHRONIC 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy perform death? certificate Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: ပ 1 Yes 200 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5/ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death I Director: After the din by the funeral 28a. Date of injury (Month, Day, Year) Time of 28b. 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be within 24 hours are.

To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number

State

Registrar ...

30. Name and address of person who

TONE

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ichard 140 AM Medical 2017 0 4a. Facility Name (if not institution, give street and number) Examiner 4b. Çity, Town, or Location of Death 4c. County of Death Baltinove BOD ACCOUNT HORATAL BATIMOTO **Funeral** 7. Age (In yrs. last birthday If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Hours 04/16/1946 218-40-6001 **Director** 1 🔀 M 2 🗆 F 66 Maryland Usual Residence of Decedent 28a-f shov 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore 1X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 902 Reverdy Road 21212 USA items 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give "natural", or þ Black, White, etc. 1 Never Married 2 X Married hours after 3 🗌 Widowed 4 🗌 Divorced 1 ☐ Yes 2 X No Specify. Completed Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the IEP Managing Chair Balto.City Schools years traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည of Health and Ments Richard Brown Sr. Mary Lee Cameron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Richard Brown III. 902 Reverdy Rd.Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/15712 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Holy Redeemer Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) NEVADDIO W 26K1 Medical Due to (or as a cons Examiner Chronic Obstinging Polyoner NIVER Sequentially list conditions ner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE. 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atfilled be detached for Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 23e. Did tobacco use contribute to the cause of death? Completed page 2 should 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 N æ

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 certificate After this funeral Director: A d in by the fi

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Certificate:

Medical

29a. Certifier

Date filed (Month, Day,

21215-0036

Maryland

Baltimore,

25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗙 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Suicide 1 Yes Investigation 2 🗆 No 6 Could not be ☐ Homicide 28f. Location (Street and Number or Rural Route Number.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year)

X1110 cause of death (Item 23a) (Type, Print) and address of person who complete

determined

OKTI 000 BALTIMOTE ATTENT

State Registrar

24 hours a

within 24 hou

To the Fune

completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OCTODEY Brown A. 11:00 AM 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Multimedical Center Baltimore Towson Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 1 🗆 M 2 💢 F 213-49-8817 Usual Residence of Decede 71 Jamaica 12 02 28a-f show death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1X Yes 2 ☐ No MD NA Baltimore ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21212 U.S.A. 816 Richwood Ave 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper Hotels 6th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Adassa Hamilton Rexford A. Pennicooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Richwood Ave, Baltimore, Md 21212 Cleveland Brown-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ¥ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Woodlawn 10/20/2012Woodlawn, Md 21. Sig 'q'ur' of Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused shock, or heart talure. List only one cause on each line. Immediate Cause (Final d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Physician/ Cardiomyopathi Severe disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be ex Division of Vital Records, P.O. Box 68760 Medical attending ph IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Yes 2 4 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Circhosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 Yes 2 No Yes 2 PNo To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 9 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify, After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 H Natural injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completely filled in by the f 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

29a. Certifier (Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cepter 7700 York Rd. Towson, MD 21204

R097104

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rma Joann Byrd		1- For State	ite of Maryla		artment of rtificate of		d Mental I	Hygiene	7	201	2 3237	
Physicia		Registrar 1. Decedent's Name (First, Middle	,Last)	001	tinodio or	Douin		2. Date of D	eath		3. Time of Death	
Medical Exami		Irma J.	Byrd						7, 2012	ear	0715 hrs	
)		4a. Facility Name (if not institution 1311 E. Patapsco Ave	, give street and nur	mber)	4	b. City, Town, or Baltimore	Location of Dea	th	4c. Coun	ty of Death N/A		
Funeral			5. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	r If Under 24H	rs. 8. Date of i	Birth(MM/DD/YY		thplace (State or	
Director		214-84-2033	1M 2XF	50	Yrs.	Months Days		n	4/1962	Foreig		
	ŀ	Usual Residence of Decedent						00/2				
w any		10a. State 10b. County			Town or Location						10d. Inside City Limits  1 X Yes 2 No	
faryland 28a-f show Lat once.	įį	Maryland N,	/A	В	altimor	e 10f. Zip Code			40- 0:4:61	Affron Cour		
or 28;	Director		o Avonio			2122	15		10g. Citizen of What Country?  U.S.A.			
17215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene. sarked other than "natural", or items 23a or 28s-f sho event, the Medical Examiner must be notified at once.	曺	1311 E. Patapsco		edent Ever in U.	S. 13. Was	Decedent of His		Specify Yes or I			ican Indian, Black,	
death or item	Funeral	1 Never Married 2 X Mar	rried Armed Fo	rces? 2 X No	If Ye	es, specify Cuban	, Mexican, Puer	o Rican, etc.)	l w	nite, etc.		
s after	à		rced If Yes, Give Year or Dates:			Yes 2 X No				Whit		
2 hour	g.	<ol> <li>Decedent's Education (Speci Elementary/Secondary (0-12)</li> </ol>	fy only highest grade College (1-	' '		's Usual Occupat est of working life.			16b. Kind of	Business/i	Industry	
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5-00 led wi Hygien other		17. Father's Name (First, Middle, L	.ast)			T,	18.Mother's Nan	ne (First, Middle	e, Maiden Surnar	,	<del></del>	
d be fillental	B	Raymond 19a. Informant's Name/Relationshi	in (Type Drint )	Si	ngleton	Address (Stree	Connie	Donal Barda N		Hawth		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Ηij					•				•	1and 21225	
e, N l and J Health item J	ŀ	Billy E. Byrd (1			Place of Disposi	tion (Name of cer		Date	20c. Locatio			
MOF Pages ent of r other		1 Burial 2 XCremation 4 Donation 5 Other Spe		III State	erematory or oth	erphace) remation	10/	09/2012	Glen	Burni	ie, Maryland	
Baltimore, permit. Pages I an Department of Hee Important: If ite	İ	21. Signature of Funeral Service L		0-732	22. Na	ame and Address	of Facility					
	4	23a. Part I. Enter the disease, or c	H		1 3	2641MyuF	real Rich	ad Pass	dena, M	aryla		
Physician // // // // // // // // // // // // //		failure. List only one cause o	n each line.			e mode or dying,	such as cardiac	or respiratory a	arrest, snock, or r	neart	Approximate Interval Between Onset and Death	
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		Sequentially list conditions,	b									
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c									
ed isit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	F):	-						
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60, ate be ex hysiciar	Med	IF FEMALE:	23c. If yes, o	utcome of pregr					23d. Date	of delivery	,	
cath certificate be attending physicar or use as the bu	ian/	23b. Was decedent pregnant in the past 12 months?	I I LIVE DI	rth ant at time of dea	oth =	al death 3 [	Ectopic pregr	ancy	Month		Day Year	
Box 68760 e death certificate be the attending physical ed for use as the by	Physician/Me	1 Yes 2 No 9 V Unkn			ath 5 Oth	er (Specify)						
		Part II. Other significant conditio	ns contributing to	death but not re	esulting in the ur	nderlying cause g	iven in Part I.				the cause of death?	
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ords,	blet								opsy	prior to c	topsy findings available completion of cause of	
tal Reco	Completed							1 ✓ Yes	formed? 2 No	death? 1 ✔ Ye	s 2 No	
ital Fician:	æ	25. Was case referred to medical examiner?	Hospital:	patient 2	ER/Outpatient		of Death (Check Other:4 Nurs	only one)	Residence 6	Other	· Scane	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  at Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated.	읽	1 ✓ Yes 2 No 27. Manner of Death	28a. Date o	of Injury	28b. Time of In		y at Work?		e how injury occu		. ocene	
Sion Attendin or death.	tio	1 X Natural 5 Pendir 2 Accident Investi	ng	Day, Year)		1 Y	es 2 No					
Visi	Certification:	3 Suicide 6 Could	not be 28e. Place	of Injury - At ho	ome, farm, street	, factory, office b	uilding, etc.	28f. Location or Town,		ber or Ru	ral Route Number, City	
Dospital hours incral	ခ်	4 Homicide determ	( ),						· · ·			
Divis To the Hospital or A within 24 hours after To the Funeral Dire	ल	(Check only 1 Certifying Phyone) 2 Medical Exam	<b>sician:</b> To the best <b>Iner:</b> On the basis of	examination ar								
To vitl	Me	29b. Signature and title of certifier	and manner sta	ated.	1	29c. License					nth, Day, Year)	
t l		Ch (1 1	11	1/1		O.C.N	И.E.		October 8	3, 2012		
0	t	30. Name and address of person w	· · · · · · · · · · · · · · · · · · ·			h: 0:						
7			ssistant Medica	al Examiner pistrar's Signatur		altimore Stree	et, Baltimore	, мр 21223	3		<u>-</u>	
Sta Registi	_	31. Date filed (Month, Day, Year)		pistrar s orgnatur	La Va							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:39 A M Physician/ Kennard Michael Broglie 2013 Medical 4a\_Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death County of Death Square HOS -imor Social Security Number Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 208 36 1055 Hours 66 Director 1 🏻 M 2 🗆 F May 30, 1946 Maryland 28a-f show aţ 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Maryland Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 872 Sue Grove Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Yes 2 XNo 1 Never Married 2 X Married Broglie, Hennard Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Consultant Computers injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Francis Joseph Broglie Rosaline Reith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 872 Sue Grove Rd. Baltimore, Maryland 21221 Carlene Broglie (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Ind. 10/8/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex anyi W. Maryland 21221 23a. prt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MyoCardia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Dertensive Arteriosclerosis Cardiovascular Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ be detached for in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown plnods Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate rmed? 2 ☐ No 1 Yes 2 No Yes 25. Was case referred to medical examiner?
1 2 Yes 2 1 No filled in by the funeral director, Be 26. Place of Death (Check only one) 2 Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 | 3 | | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ca 29d. Date signed (Month, Day, Year) 0

Registrar

State

vald 9000 Franklin Square Dr. Balto, 40

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 30 Physician/ 08:20M Wayman Bosley 2013 Anthony Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSpital of Battimore Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Min (Month, Day, Year) Director 212-28-6684 1 X M 2 □ F 07/02/1931 Michigan 81 Usual Residence of Deceden of Health and Mental Hyglene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Director WAY MAN 1 Ves 2 X No Jarrettsville Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21084 U.S.A. 3917 Grimm Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. <u>چ</u> 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. <sup>Specify:</sup>American Indian 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Industrial Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing 12 Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file h and Mental I is marked o ္ဝ Boslev Edith Schrewsbury George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. 1762 Hoke Road, Sevens Valley, PA 17360 Tonia Rose Bosley / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/05/2012 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry Hanover, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovasaular Accident Physician/ ease or condition week ) Medical resulting in death) Due to (or as a consequence of): Examiner fibrillation year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
It hours after death.
Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 Yes 2 No 9 Unknown Division of Vital Records. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Hypothyroidism 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Prostate cancer, Depression 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No HOSPIC ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ✓ Natural 5 Pending ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my antique of the cause (s) and manner as stated. Medical within 24 hou To the Funer completely fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES OOO M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sinai Hospital of Battimere, 2401 w. Schedere A AB Anilua MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

OCT 1 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201<sup>Year</sup> Physician/ Chickpui Chan October 4:10  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 18804 Broken Oak Road Boyds Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Days Hours Director 219-71-0011 1 🏻 M 2 🗆 F Oct. 2, 1933 China 79 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Boyds Montgomery 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 18804 Broken Oak Road 20841 China death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. and Mental Hygiene. Is marked other than "natural", or i 1 Never Married 2 Married 72 hours after Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Asian 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Shoemaker Manufacturing 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Cheng Seung Chan Hop Wong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 18804 Broken Oak Road Boyds, MD 20841 Lau Yeung / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 10/18/12 Woodbine, MD f Ineral Service Licensee <sup>22</sup> Name and Address of Eacility Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Rectal Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) jo in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of page performe death? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural 5 Pending ☐ Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 October 8, 2012 ss of person who completed cause of death (Item 23a) (Type, Print) Coleman 1355 Piccard Dr. Suite 100 Rockville, MD 20850 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18:28 Month Physician/ aibson Ortober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 00 Maryland Medical Center University Baltimore 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 1 2 🗆 F 219-40-0342 March26, 194B 69 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Essex 10b. County 10a. State 10d. Inside City Limits Director Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 USA 432 Virginia Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired)
Steel Worker Elementary/Seconday (0-12) 12th College (1-4 or 5+) Beth Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Elizabeth M. ပ Cartter John P. Coyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Coyle /brother Washington Road New Freedom PA 17349 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 10/11/12 Baltimore MD 4 Donation 5 Other (Specify) 21. Sign sure of Funeral Service Licens 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ypoxemio Physician/ disease or condition Medical resulting in death) Due to (or as ardiomyopa Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that intrinses or the control of Examiner attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death signed by the a 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate has page 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes ၉ 1 Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 1💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 1285900803 MDOcto ber 2012

State Registrar Adnan

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Baltimore

Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khera

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $A^{M}$ Anthony Martin Clay 10 2012 8.00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6525 Parnell Avenue Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/11/1961 Birthplace (State or Foreign Country)
 New York Social Security Number Funeral 6 Sex 7. Age (In yrs. last birthday) Months Days 1 M 2 □ F Director 215-82-8552 51 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 ☐ No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6525 Parnell Avenue 21222 Was Deceue.
Armed Forces?
Ves 2 No 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Painter Service 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file n and Mental H 7 is marked of ည William Clay Anna Porreca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Angela Clay / Wife 6525 Parnell Avenue, Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/9/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death -Physician/ ver CANCER Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Day Month signed by the at Id be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been significate has been significated funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Dending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number W eted cause of death (flery 23a) (Type, Print) 6701 N. Charles 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Medical 4a. Facility Name (if not institution, give street and number) . City, Town, or Location of Death **Examiner** 4b 4c. County of Death last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country Illinois **Funeral** 1 M 2 F 199-38-2521 Director 64 Usual Residence of Decedent 28a-f show notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No VA Fairfax Reston 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral with 1 20191 Ouorn Lane 20191 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Nivorced Specify Completed White er than "natur, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.
27 is marked other than r traumatic event, the Mo Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Public Health Executive Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be ment of Health and Ment Stanley Ford Madeleine Sauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is Leslie Ford / Sister 1430 Willamette Street #120, Eugene, OR 97401 20a. Method of Disposition
1 
Burial 2 
Cremation 3 
Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State Department or Important: If any injury or once, Chesapeake Crematory 4 Donation 5 Other (Specify) 10/10/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Doug Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions Examine: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after reach that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 & signed by the attending physician of be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy performed? Yes 2 No death? 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? ☑ Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direc Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

600

2128

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SMUT

MARIE-ANNE

31. Date filed (Month, Day,

				Plea	ise Typ	e or F	Print in	Black	Indeli	ble Inl	k. Ens	ure A	I Copie	s Ar	e Legi	ble.		
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			State Registrar					C	ertifica	te of L	Death			Reg. No. 2012 32386				
	Physicia	in/	1. Decedent's Name		, Last)	Μ.							2. Date of De Month		av	Year	3. Time of Death	
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Œ	Examir	ier	Greater				,	Cent	4b. City, Town, or Location of Death					4	c. County o	f Death Ltim	0.22.0	
Andreas of	Funeral		5. Social Security N		6. Sex		Age (In yrs.			er 1 Year			8. Date of Bi	rth	Ба.		lace (State or Fore	ian
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	D W		Usual Residence of 10a. State	of Decedent 10b. County							Jan. 2	26,19	934	MD				
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	or 28e	Dire	MD 10e. Street and Nun		timor	<u>e</u>	<u> </u>	Gywnn		ip Code				40 0			1 🗆 Yes 2🏋	No
	23e c	ra		lton Dr	rivo				101. 2	21207	7			-	itizen of W		•	
	ems rems	Funeral Director	11. Marital Status	I COIL DI	12. W	/as Decedermed Force	nt Ever in U.	S. 13	. Was Dec	edent of Hi	spanic Ori	igin? (Spec	ify Yes or No		nited 14. Race			
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8	uthin 72 hours after death with the Maryland liene. Fr then "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at	Completed by	3 Widowed		Ye	Yes, Give ear or Date	S		1 L Yes	2414No	Specify:				Specify:	]	31ack	
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p	e filed w tal Hyg ed othe event,	Be	17. Father's Name (I	First, Middle, L	ast)			1 111	CCIISC				(First, Middle	Maiden		L CII	Jare	
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Σ	alth n 27 or tre		Harold L.	. Catle	tt (h	usban	d)						Oak, M		21207			
ore	ge 1 end it of Heal if Item 3	П	20a. Method of Disp 1 X Burial 2		3 D Romo	val from St		Place of Dispermentary, cr	osition (Na	ame of other place	e)	D	ate	20c. t	ocation - C	City or To	wn, State	
Ē	Pag tment tent: jury c		4 Donation	5 Other (S	pecify)	var nom or	Gan	rison	Fore	st Ve	t.	10-19	-2012	Owi	ings 1	1i11s	s, MD	
Baltimore, Maryland 21215-0036	permit. Page 1 Department of Importent: If it eny injury or o		21. Signature of Fur	11					22. Name a			•	ELINE					
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- 6			23 Part 1. Enter to she or hear Immediate Cause (I	t failure. List o	nly one caus	se on each	line.	th. Do not er	iter the mo	de of dying	g, such as	cardiac or	respiratory a	τest, ►			Approximate Interval Between	
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X	attend for us	clan	23b. Was decedent in the past 12 n	nonths?	1	Live Bir	th 2 D Feta th at time of	al death 3	☐ Ectopic		y				23d. Date Mont		ry Day Year	
Ď.	the d	ysi	1 ☐ Yes 2 ☐ 9 <b>☐</b> Unknown	l No		Unknov		ueatti 5	□ Other (	specily)					W.O.I.		July Tour	
<u>Р</u> О	thet ti	by Pi	Part II. Other signifi	cant conditio	ns contribut	ting to deat	h but not res	sulting in the	underlying	cause give	en in Part	l.	23e. Did t	obacco	use contrib	ute to the	cause of death?	_
ļs,	ulres n sigr uld be	q pa											1 🗆	Yes 2	□ No 3	☐ Prob	ably 4 Unkno	wn
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<u></u>	len: '		25. Was case referre examiner?	/						26. Pla	ce of Dea	th (Check o		2 12 1	ioj i	_ 1es .	2 1110	
₹	hysic his of	2	1 ☐ Yes 2 2	No	Hospita	1 Inp	atient 2 🗆			Othe	r: 4 □ Nu	ursing Horr	e 5 🗆 Resi	dence (	Other	(Specify)		
2	ling P	Certificate:	<ol> <li>Manner of Death</li> <li>Natural</li> </ol>	5 🗌 Pending		a. Date of i (Month,	njury Day, Year)	28b. Time injury		28c. Injury work?	?		3d. Describe I	now injui	y occurred			
Siol	death death stor: ,	tific	2 Accident 3 Suicide	Investig	ot be	Dlage of	laires. At he		M		Yes 2 🗌	-						
Division of Vital Records,	l or A after Direct	Cer	4 Homicide	determi	ned 200	building,	Injury - At ho etc. (Specify	me, ram, s	reet, racto	гу, опісе		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use es the by	Medical	29a. Certifier 1	Certifying	Physician:	To the best	of my know	ledge, death	occurred	at the time,	, date and	place, and	due to the c	ause(s) a	and manner	as state	d,	
	he Ho lin 24 he Fu iplete	Med	(Cneck 2	☐ Medicat E	caminer: On	i the basis o	of examination	n and/or inve	stigation, ir	my opinior	n, death oc	curred at ti	ne time date a	and place	and due to	o the caus	se(s) and manner st	ated.
	Sor With To		29b. Signature and t	itle of certifier	1				29	c. License	number	-1		29d. Þa	nte signed (	Month, D	ay, Year)	
										1-14	tu (	1+	/	6/1	111	1		
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	Stat	e	Irina Med 31. Date filed (Month		•n• (		N. Cha		orree	L 10	wson	<b>,</b> MID	21204	•				
	Registra		0	CT 10	2012	Dans	ر به	1. 1	ale									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 310e Per FH G932 10/11/2012 Jh State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2012 11:30A<sup>M</sup> Mildred Τ. Chesser October 6. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FutureCare - Canton Harbor Baltimore City If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 217-26-0684 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 82 **Director** June29.1930 Marvland Usual Residence of Decedent hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2□No Director Md. Baltimore City 10e. Street and Number 625 528 South 10f. Zip Code 10g. Citizen of What Country? 0 items 23a South Belnord Avenue Funeral 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: <u></u> Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sprayer & Packer Shoe Factory is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental William Piercy Ruth F. Geigan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Cindy Chesser - Daughter 339 South East Avenue Baltimore, Md.21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 10,2012 Baltimore, Maryland M00933 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licens Robert 1201 Dundalk Avenue Baltimore, Md.21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MRSIT **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 ₩ been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Onknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 1 □ No autons performe 1 ☐ Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: All Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 PH 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 8, 2012 erson who completed cause o Poeberily My-1/234

X DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 32388 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ( arroll October attie trances 20/S 7:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner or Location of Death 4c. County of Death 3705 West Coldspring Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 213-30-3274 **Director** 1 □ M 2 🗹 F April 27, South Carolina or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Margland 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3705 West Coldspring Funeral 21215 United States 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Newer Married 2 Married δ 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me State Hospital Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reuben Montgomery Bertha Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1527 North Ellament Street Balhmore, MD. 21216 Marietta Talbott-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 16 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Owings Mills, Maryland Garrison Forest Vet. Cem. 2012 4 Donation 5 Other (Specify) Signative of Funeral Service Licensee 22 Name and address of Facility inc. P.A. Darker Funeral Heine, P.A. 3512 Frederick Avenue Baltimore, MD. 21229 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final et and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conseq Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery Division of Vital Records, P.O. Box in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 No ☐ Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မြ 1 Yes Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of co State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2012 32389

Swendolyn Epp	_	1- For State Certificate of Death Registrar	-	∠ U 1 eg. No.	2 3230
Physici		1. Decedent's Name (First, Middle,Last)	2, Date of Deat Month		3. Time of Death
Medical Exami	ner	GWENDOLYN EPPS  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea	October 6		1032 hrs
		Johns Hopkins Hospital  Baltimore	ui	4c. County of Dea	ui
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H		th(MM/DD/YYYY) 9. B	
Director		212-72-7743 1 M 2 F 52 Yrs. Months Days Hours Mi	02/27	1/1960	country) MD
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
. ₫	L	MD BALTIMORE			1 X Yes 2 No
faryland 28a-f show 1 at once,	ecto	10e. Street and Number 10f. Zip Code	10	Og. Citizen of What Co	untry?
ith the Maryland 23a or 28a-f sho notified at once,	Dir	829 N. KENWOOD AVENUE 21205		USA	
, MD 21215-0036  and 2 should be filed within 72 hours after death with the Maryland tealth and Montal Hygiene.  tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Survey Neuronal Process) 14. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Origin? (Survey Neuronal Process)		White, etc.	erican Indian, Black,
ter dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: AA	RICAN 1ERICAN
ours af atural	d by	15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind of		16b. Kind of Business	
215-0036  se filed within 72 hours at tal Hygione. ked other than "natural not, the Medical Examin	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  during most of working life. DO NOT use re		0=	
Joseph Control of Michigan Control of Michael Contr	mo	17. Father's Name (First, Middle, Last)  NURS ING ASSISTA I	UT ne (First, Middle, N	JELF - E	MPLOYED
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	Be C		E JONE		
ID 21 ! should I and Mer 27 is man	٩		Rural Route Num	ber, City or Town, Stat	
, MD and 2 sho ealth and tem 27 is		DORINE JONES MOTHER 426 E. 28th ST. E	Date Date	2E, MD - Z	r Town State
Baltimore, Normit. Pages 1 and Department of Health Important: If item		aromatory or other place)			
Baltim permit. Pa Departmen Important injury or or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Septice Licensee  22. Name and Address of Facility	11640 B	DEFALCE	NEDA SUC
Balti permit. Departu Importi		Lebua Casino Mos 40 4905 York Road 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	O. BAV	TIMORE,	MO 21212
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	est, shock, or heart	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardiov Due to (or as a consequence of):	ascular	Disease	Death
		Sequentially list conditions,  b			
	iner	if any, leading to immediate Due to (or as a consequence of):			
iit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		·	
xecuted n and l-transit		AMENDED 23a,pt.II,27,per me,g933 11-29	)-12 sm		-
de burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	N .
687 ertifica ding ph	an/N	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregr	nancy	Month	Day Year
that the death certific ned by the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			
O. Entre of the charter of the chart		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
S 50 9	d by	diabetes mellitus, hypercholesterolemia	1 Yes	2 No 3 Pro	obably 4 V Unknown
Division of Vital Records, Falor Attending Physician: The law requires its after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed		24a. Was a autops	sy prior to	utopsy findings available completion of cause of
Rec The 1a icate h page 2	E O		1 Yes 2		res 2 No
ital Reician: The sector, page	æ	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 Nursi		Residence 6 Othe	
of Vi ing Physi After this uneral dir	۲.	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Residence 6 Othe	ar.
OD (sending sath.	tion	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)  1 Yes 2 No			
ivisi or Att after de Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, St		ural Route Number, City
Divis ospital or / hours after uneral Dire y filled in the		4 Homicide determined (Specify)  29a. Certifier 4 Continue Physician To the best of my keyword as the stime date and place as			
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To with	Me	29b. Signature and title of certifier 29c. License number		29d, Date signed (Mo	onth, Day, Year)
		Thooken M. Kird JR. M. D. O.C.M.E.		October 7, 2012	
0	ľ	30. Name and address of person who completed cause of death (flem 23a)  Theodore M. King, Jr. M.D. Assistant Medical Evaminary, 200 M. Baltimore Street	Politimana MED	21222	
\ \	ate	Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, E  31. Date filed (Month, Day, Year)  32. Registrar's Signature	oaitimore, ML	21223	
St Regist		OCT 1 0 2012			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First\_Middle\_Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Massie Marie Easlev 2012 Oct. 2:40 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Always Caring Columbia Howard 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 460-30-4920 Director 1 M 2 XF 83 April 11,1929 Texas Usual Residence of Decedent show at 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2 XNo Columbia Howard 10e. Street and Numbe ö 10f. Zip Code 10a. Citizen of What Country? 23a Funeral 21044 USA 5419 Hildebrand Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Examiner Armed Forces Black, White, etc. Africian ò 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify. "natural" 3 Widowed 4X Divorced Specify Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation 16h, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working d Mental Hygiene. marked other than life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Secondary Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Callie Carter Elijah Lewis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Department of Health Important: If item 27 any injury or other tr Benee Easley / daughter 5419 Hildebrand Court Columbia, MD 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 10/9/12 Woodbine, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Eacility
Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 5-6 min Death Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 3-4 days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Alzheimer's Disease (End Stage) burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year the 9 Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Failure page 2 should Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of Coronary Artery Disease certificate has performe death? Multiple Decubiti (pressure ulcers) Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted 1 ☐ Yes 2 ☐ No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Director: After 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Sulciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of q 29c. License number 29d. Date signed (Month. Day, Year,

Registrar DHMH 17 Rev 06-2011 30. Name and address of

31. Date filed (Month, Day, Year)

OCT 1 2 2012

John Serlemitsos,

Box 68760

P.O.

Records,

Division of Vital

D0032654

M.D. 2033 Penderbrook Dr. Crownsville, MD 21030

October 8, 2012

person who completes cause of death (Item 23a) (Type, Print)

09584W Stephen Everett 10/03/2012

			Please	Type or Pri								Legible.	
			for State Registrar	State of Ma	arylan	-	artment of I rtificate of I		and Me	ntal Hy	giene Reg. No.	2012	32391
	Physicia	n/	Decedent's Name (First, Middle, Las	st)					2.	Date of De	eath		3. Time of Death
	Media	cal	Stephen Michael  4a. Facility Name (if not institution, give	Everett and number			4b. City, Town, o			ctobe		,2012 <sup>Year</sup>	9:08A. ™
	Examir '	ei	2019 Frames Roa	_			Dunda]		or Death			County of Death	
	Funeral Director		5. Social Security Number 6. Se		e (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Bir (Month, Da	v. Year)	Cou	hplace (State or Foreign intry)
			Usual Residence of Decedent						I IM	ay 13	,1969	9   Mar	cyland
	ayland a-f sho ied at	Director	10a. State 10b. County	_		, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	the Ma or 28a e notii		Maryland Baltimo	re	DC	ındalk	10f. Zip Code				10g. Citi	izen of What Cou	
	th with ns 23a must b	Funeral	2019 Frames Road		_		21222				U.	S.A.	
(0	or iten niner	by Fu	11. Marital Status 1 ☒ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 \(\sum \) Yes 2\(\begin{align*}{c}\)			Was Decedent of H f Yes, specify Cuba	lispanic Oriç an, Mexican	gin? (Specify n, Puerto Rica	Yes or No- an, etc.)	.	14. Race - Amer Black, White	
21215-0036	ursaft tural", al Exar											Specify: White	
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212	l withir ygiene her tha t, the l		Elementary/Seconday (0-12)	College (1-4 or 5	+)	Pair					Hom	e Impro	vement
Maryland	be filed antal H ked ot c ever	To Be	17. Father's Name (First, Middle, Last)  Kenneth Everett						er's Name <i>(Fi</i> :ry Cav			Surname)	
lary	should and Ma is mar		19a. Informant's Name/Relationship (T)	pe, Print)		19b. Mailir	ng Address (Street					Town, State, Zip	Code) 21222
e, ≥	and 2 g Health em 27 ther tra		Andrew M. Evere	tt	Taa: =:			rge's			_		,Maryland
mòr	age 1 ent of i		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Cre	matio	sition (Name of patory or other place	ce)	Date 10-8-			cation - City or	
Baltimòre,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens		_ cer		f Marylar Name and Addre					over,Mar ral Char	
Ш	20 <b>5 6 8</b>		23a. Part 1. Enter the disease, or com	galli-	the death	Do not onto	2. Name and Address 2009 Harfo	ord Ro	oad,Ba	ltimo	re,Ma	aryland	
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	Medical Examiner		disease or condition resulting in death)	a. Due to (or a	conseque	ence of):	rangi	1				-	
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Box 6	law requires that the death certificate be ex nas been signed by the attending physician s 2 should be detached for use as the buria	by Physician/Medica	in the past 12 months?	23c. If yes, outcome of 1 Live Birth 4 Pregnant at	2 🗌 Fetal	death 3 [	Ectopic pregnand Other (specify)	<sub>Б</sub> у			2	23d. Date of deli	very Day Year
B	the dea	hysic	1 Li Yes 2 Li No 9 Li Unknown	9 Unknown	urne or de	eath 5 L	Other (specify)					WOTEN	ouy rear
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Vita	ician:	Be	25. Was case referred to medical examiner?	Hospital:					th (Check onl	y one)			
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00	eath. or: Afte the fun	Certificate:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☑ Suicide 6 ☐ Could not be		212 (	39081		? Yes 2		140		INC	
Division of	l or Att after d Direct I in by	Cert	4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At hon (Specify)	4.4	eet, factory, office		~	Location (S City or Tow	Street and (n, State)		Nev Id
_	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director. After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examir	ician: To the best of r	ny knowle	dae, death c	occured at the time.	, date and p	place, and du	e to the car	use(s) and	manner as state	ed. ause(s) and manner stated.
	o the F vithin 24 o the F omplet	Me	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the b	est of my	knowledge, c	leath occurred at the	e time, date	and place, ar	nd due to the	e cause(s)	and manner as s	tated.
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	Jan	4	30. Name and address of person who c	propleted cause of de	ath (Item 2		1   17	111	~,	44 -	101	1 M-	121083
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	Registra	ır	OCT 1 0 2012	Sente	Ø.	par							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Evans, Sr 06 9:50 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore . Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 216-30-8761 Director 1 XM 2 | F 77 Baltimore, MD Dec.20,1934 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? Funeral 7904 Bon Air Road 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian e filed within 72 hours after di ttal Hygiene. ed other than "natural", or if event, the Medical Examine Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Richardson & Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. Lead Lineman Wayland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Joseph Evans Ethel Regina Hornberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4237 Norrisville Road, White Hall, MD 21161 Katherine Cook-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Evans Funeral Chapel Bel Air 1 Burial 2 K Cremation 3 Removal from State October Forest Hill, MD 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, MD 21234 22. Name and Address of Facility Chapel & Evans Funeral Chapel & 8800 Harford Road Parkv

23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ a. Right Intraccrebral Hemorrhage
Dad to (or as a consequence of): disease or condition resulting in death) Medical Examiner Incontrolled Hypertension Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? artery disease, atrial fibrillation, dyslipidemia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown benign prostatic hypertrophy, chronic obstructive pulmonary 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? disorder 2 **N** No 2 N 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: ဂ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 10/06/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8201 Loch Raven Blvd. Baltimore, MD 21239 Tsai Samaritan Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signatu Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2005 06 2012 Jeanne Liliane Faust Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford **Examiner** Havre de Grace Harford Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🖾 🛠 1072171918 Director France 197-10-8206 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Churchville Maryland Harford 1 Yes 2 No 10f. Zip Code 9 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral 21028 126 Hopewell Road USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo Specify: If Yes Give Specify: 3 XWidowed 4 ☐ Divorced white Completed Year or Dates. U Hygiene. other than "natur rent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) sales representative clothing 1 and 2 should be filed wi f Health and Mental Hygir item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Auger Marcella Cordivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 126 Hopewell Rd., Churchville, MD 21028 Madeline Zdon (daughter) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State 4 ☐ Donation 5 🖾 Other (Specify) encombmen cemetery, crematory or other place, Harford Mem. Gardens 10/10/2012 Aberdeen, Maryland 21. Signature of Funeral Service Dicenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No or Attending Physician: appleted filled in by the funeral director, Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be Accident 24 hours after deat Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, Statel Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I 30. Name and address of person of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #22 Per FH 9932 10/10/2012 Jh. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death S·50 P M Physician/ LOOD 2012 1ARIE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 70 If Unde Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 231-30-8624 Hours Director 1 M 2 M F 13-922 should be filed within 72 now...
I should Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-1 such a marked other than "natural", or items 23a or 28a-1 such a marked other than "natural". 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits STOWN 1 Yes 2 No tim ore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9533 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced Blac Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) eacher permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Han 19a. Informant's Name/Relationship (Type, Print) ber, City or Town, State, Zip Code) llstown, MD 21/33 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 13-2012 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death ARDIOGENIC SHocle Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed? A hours after death that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician ; page 2 should be detached for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pre 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 mont Pregnant at time of death Month Part Nother significant conditions contributing to death but not resulting in the underlying cause given in Part I by 23e. Did tobacco use contribute to the cause of death? MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy 2 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) ieu examiner? Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1) 28575 ADIODIA nus Name and address of person who completed cause of death (Item 23a) (Type, Print) P.ODOr MINEEM AKHANI 1523 FILL AN WIM WANING 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 0 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year AL Fred Fisher FOSTEY October 4:20 A M Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban 9. Birthplace (State or Foreign Country) HUSPITAL Bethesda Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours 239-46-4160 Director 1 M 2 🗆 F 78 March 7 /934 North Carolina 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver 1 Yes 2 No Mary | and MONTGOMERY 10e. Street and Number 10g. Citizen of What Country? Funeral # 704 EAST Mill Way 20910 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 

If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: Black 3 🗌 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) \* Elementary/Secondary (0-12) College (1-4 or 5+) Howard University Administrator 12 Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Virginia Fisher Miles MAYK Ada 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 & 912 704 EAST IVEN SPYING, Janice Jones Fisher - Wife 8010 Blair Mill Way Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ₩ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Durham, North Carolina Beech wood cem. 10-15-12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fisher Funeral 21. Signature of Funeral Service Licensee 27707 Palor Fisher Funeral Palor 37 Fayette Ville ST. Durham, Curvinna 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEYMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Lung Cancer Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 71517 10-8-12 D

Registrar

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Natalia

Date filed (Month, Day,

OCT 1 0 2012

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ALFRED

8600

old George Town Road

Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vasgue Z

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct.5,2012 Annette H. Fowlkes 4:25 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Nov. 3, 1954 Director 218-62-3513 1 □ M 2 13 TF 57 Usual Residence of Decedent 10a, State filed within 72 hours after death with the Maryland or than "natural", or Items 23a or 28a-f sho the Madical Examinar must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4027 Bellwood Ave. 21206 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ş 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specity: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) el Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pege 1 and 2 should be filed wit Department of Health and Mentel Hygies Important: If Item 27 is marked other 1 any Injury or other traumatic event, the once. Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Hosley Jr. Ella Bell Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 10034 Hilgreen Circle Apt.J Cockeysvilld, MD Marvin Johnson (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carmel Cem. Odt. 11,2014 Baltimore, MD 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home
1412 F. Preston St. Balto 21. Standard Funeral Scroom Liversee 23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the deeth certificate be executed Cause (Disease or injury that initiated events ettending physicien and for use as the burlal-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760  $C_{
m c}$ Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day the Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home \( 5 \sum \) Residence \( 6 \sum \) Other (Specify) \( \frac{1}{2} \) မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurs Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl certifie 29d. Date signed (Month, Day, Year) 0071287 Name and address of person who completed cause of death (Item 23a) (Type, Print) St. \$ 4105, Baltimore, MD 21200 houles State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day EM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4708 Tecumseh Street College Park Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Davs Hours Min. Apr 18 <sup>4</sup>1950 Director Maine 005-52-2815 1 0M 2 1 F 62 r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 XYes 2 No MD Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4708 Tecumseh Street 20740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ≥ 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Completed 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If ftem 27 is marked other than "na any injury or other traumatic event 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ Federal Government Under Secretary of Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Richard Woodman Gerry Corinne Paddock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4708 Tecumseh Street College Park, MD 20740 Dale M. Ahearn/wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 10/09/12 4 Donation 5 Other (Specify) Woodbine, MD 22. Name and Address of Facility Going Home Cremation Service P.O. Box Beverly L. Heckrotte, P.A. Clarksville 21. Signal of Funeral Service Lice 784 MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been significate has been significated funeral director, page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) ဂ္ဂ 1 🗌 Yes 2 1440 Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this letely filled in by the funeral s 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical To the Hosp within 24 hou To the Funel completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) gn Highway 30. Name and address of person who cor noieted caus death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

32. Registrar's Sig

12-07428 Earl Garrison Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

an Gamson	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Parkland   0	
Physician	Month Day Year	_
Medical Examine	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	_
	2214 Cedley Avenue Baltimore	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Country)  Yrs.  Yrs.	
k	Usual Residence of Decedent	_
yland 1-f show any Lonce.	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit 1 Tyes 2 N	
with the Maryland us 23a or 28a-f sho he notified at once are are are are are are are are are ar	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  2442 TERRA FIRMA RD.  10f. Zip Code  4,5,A	
er death		
ours aft attural ramine	or Dates:	_
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	
be fill half i ked fill Be	RAR/ JONES BARBARA (SMRRIGON)	
MD 21 d 2 should th and Me n 27 is ma turn atte ev	ANNETTE CAPPISON HOT ROUNDVIEW PD. BATIMORE MD, 21225	-
Baltimore, MD 2 permit Pages I and 2 shou Department of Health and A Important: If Item 27 is n injury or other traumatic	20a. Method of Disposition  1	
Baltimo permit. Page Department of Important: injury or ott	21. Signatura of Funeral Service Lips not	
Physician	23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and	
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Upper Gastrointestinal Hemorrhage  Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
ted Insit	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):	_
60, ate be executed hysician and e burial - transit	MENDED AMENDED 23a,-b,27,pe rme,g932 10-17-12 sm  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	_
5876C rtificate ing phys as the by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy  Month  Day  Year	_
). Box 6876 the death certificate by the attending phyched for use as the Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
P.O. res that the signed by be detached by Pl	1 Yes 2 No 3 Probably 4 Unknown	
Records, The law require are has been si age 2 should b	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of	
tal Rec		
Vital Recysician: The his certificate director, page	25. Was case referred to medical examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other A Nursing Home 5 Residence 6 Vother: Scene	
on of value Ph. ath.  r.: After tile funeral tion: To	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	
Division of pital or Attending ours after death. ours after death. filled in by the further than the further	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	<i></i>
the Hosp hin 24 hou the Fune upletely fi	29a. Certifier (Check only one)  29a. Wedical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  39a. Certifier (Check only one)  2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To with To con	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	_
	Carol Hallan O.C.M.E. October 2, 2012	
	30. Name and address of person who completed cause of death (Item 23a)  Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar		
DHMH 17 Rev 1/2001	OCME ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5, per fh, g933 11-9-12 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar 32399 Certificate of Death Reg. No. 7 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3.05 A M Physician/ Month David L. Green Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death auare timone ose In yrs. last birthday) **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 2/25/55 Country) 57 **Director** 1 **X** M 2 □ F MD 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Harford Darlington 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3309 Hughes Road 21034 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. o þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify.White 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16b. Kind of Business/Industry eel & 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Green, Davic Elementary/Secondary (0-12) College (1-4 or 5+) Reliance Aluminum Truck Driver 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Albert B. Green j Ware Dolores 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3309 Hughes Rd. Darlington, MD 21034 Dolores J. Green (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 10/12/12 Baltimore, MD 4 Donation 5 Other (Specify) Holly neral Servi 🔊 License 22. Name and Address of Facility Connelly Funeral Home 21. Signature Essex 300 Mace Avenue Baltimore, MD 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) / Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). ician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: . use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown detached Unknow P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural
2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Rurse Practitioger: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely within 2 To the 1 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 555885 Name and address of person who completed cause of death (Item 23a) (Type, Print) KO 9000 Fran guare State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 Year 2012 Dolores Theresa Gallier РМ Medical 11:45 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore Social Security Number Funeral 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Months Min. Country) Maryland Hours (Month, Day, Year) 10/03/1932 Director 1 □ M 2 1 F 212-28-7560 80 Usual Residence of Decedent 10a. State 10b. County other than "natural", or items 23a or 28a-f sho rent, the Medical Exercitor must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 ☐ No MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8011 Yellowstone Road 21087 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 ☐ Yes 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F ပ္ permit, Page 1 and 2 should be f Department of Health and Menta James French Marie Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Zajdel / Daughter 8011 Yellowstone Road, Kingsville, MD 21087 Important if Iten any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/10/2012 Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility 16. learthall . D. Dorota Marshall Maryland Cremation Services, PO BOX 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit resulting in death) Last Due to (or as a consequence of) attending physiclan for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (snecifu) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day s after death. I Director: After this certificate has been signed by the al Id in by the funeral director, page 2 should be detached fi 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N.N. 1 Yes Division of Vital Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XINo Other: 4 Nursing Home 5 Residence မြ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in To the Hospital within 24 hours To the Funerail Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in magnitude and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one daitle of certifier M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5701 N Chances State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Z8 Zolz eorge 3 reane 11 (5 PM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death FUTURE CARE NURSING 9106 PINE VIEW LANE PRINCE GEORGE COUNTY CLINTON, MD Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours Min. (Month, Day, Year) 229-48-3387 **Director** 1**X**] м 2□ F VIRGINIA 75 05/16/1937 should be filed within re....
and Mental Hygiene.

I is marked other than "natural", or items 23a or 28a-1 o...

I is marked other than "natural", or items 23a or 28a-1 o...

I is marked other than "hadical Examiner must be notified at. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits WALDORF, MD ST. CHARLES COUNT MARYLAND 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5204 SAUGER COURT 20603 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 X Widowed 4 ☐ Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PAINT MIXER PAINT COMPANY 12th17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filed treent of Health and Mental H tant: If item 27 is marked oti jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname)
BETTIE COLLINS ALFRED GREENE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20603 5204 SAUGER COURT - WALFORF, MD NANCY ASHTON - SISTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Opnation 5 Other (Specify) BETHEL GROVE BAPICOLOURCH CEMETERY OCT. 6, 2012 CLOVER, VIRGINIA 21. Signature of Funeral Service Licensee METROPOLITAN FUNERAL HOME 5517 VINE ST., ALEXANDRIA, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neu mon 1 A disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and defacted for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? -provic To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 815 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No မြ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deati To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29b. Signatu d title of )00533 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20735 2106 (ne view ane

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Y

1 0 2012

32. Registrar's

Physician/ ohn Flenry Hawes 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death Harford Memorial Hospital Havre de Grace Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6. Sex 1 M 2 D F 7. Age (In yrs. last birthday) **Funeral** May 6, 1941 Days 71 Months Hours Yrs Director 229-44-9598 Usual Residence of Decedent show 10a, State 10b. County 10c, City, Town or Location Examiner must be notified at Director 28a-f Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 402 Lorraine Street 21001 12. Was Decedent Ever in U.S.

Armed Forces?

1 № Yes 2 □ No 1958—
If Yes, Give 1978
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or <u>م</u> 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Reuben Hawes Mary Louise Beach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Lorraine Street, Aberdeen, Maryland 21001 Beverly Hawes (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 La Cremation 3 ☐ Removal from State injury or R.A.Ferris & Comp. 10/8/2012 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 any 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Respiratory Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner neumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the burial Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ned by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign tailure Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Diabetes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 per FH G932 10/10/2012 JH. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed: death? 2 XIVO ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 2 🗆 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

10/6/2012

23d. Date of delivery

Month

Day

Year

Reg. No. 2

06

USA

2012

4c. County of Death

Harford

3. Time of Death

06:41

9. Birthplace (State or Foreign

10d. Inside City Limits

Onset and Death

1 XYes 2 No

Virginia

14. Race - American Indian, Black, White, etc.

Specify: white

Government

2. Date of Death

within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral

Be

Certificate:

Medical

Division of Vital

State Registrar

James B. Sampsom 31. Date filed (Month, Day, Year)

30. Name and address of person who completed

29b. Signature and title of certifier

25. Was case referred to medica

5 Pending

Investigation 6 Could not be

determined

examiner?
1 Yes 2 No

27. Manner of Death

1 🖾 Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier (Check

For State Registrar

1. Decedent's Name (First, Middle, Last)

600 Wolfe ST Meyer 8-108 Balto, Md 21278 , Registrar's Signature

28a. Date of injury (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

1 Npatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at

1 🗌 Yes

				Please	Type or Pri					-		Legible		
			1 - For State Registrar		State of M	arylan	-	tificate of i		Mental Hy	Reg. No.	201	2 32403	
1.m.	Physic Med	cian/ dical		IVN E	Elizabe	+6	Hr:	210		2. Date of De Month		9 Year	3. Time of Death 2 0540 A <sub>M</sub>	
10	Exam		4a. Facility Name (if n	of institution, giv	e street and number)	ical	Ctr	4b. City Town, c	or Location of Dea	d D		County of Dea	th /	
5,1	Funer Directo	_	5. Social Security Nur 218-42-24	mber 6.		e (In yrs. Ia 67	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth	9. Bir	thplace (State or Foreign ountry) RYLAND	
3	and show d at	Į	Usual Residence of D	10b. County			, Town or Lo						10d. Inside City Limits	
16	th with the Maryland ms 23a or 28a-f show must be notified at	Direc	MD 10e. Street and Numb	HARFO	RD	E.	DGEWOO	D 10f. Zip Code			10a Citia	zen of What Co	1 Yes 2 No	
`,	with the same as a casa can anust be	neral	2407 HAN						040		rog. Oniz	USA	ountry?	
DOD 19/09/12	r ite	Completed by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Was Decedent I Armed Forces? 1 Yes 2X If Yes, Give Year or Dates.	Ever in U.S No		Vas Decedent of F Yes, specify Cuba		Specify Yes or No- to Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: WHTTE		
101	15-0 72 hou n "natu Aedical	nplet		15. Decedent's ify only highest g	rade completed)		(Give I	ent's Usual Occup aind of work done ONOT use retired	during most of wo	orking	16b. Kin	nd of Business	Industry	
25	212 J within ygiene. her tha ht, the f	e Co	12TH GRA	DE	College (1-4 or 5	5+)		R ACCOUN			ACC	OUNTING	GOFFICE	
De	land be filed ental Hy ked oth	To Be	17. Father's Name (Fi							ame (First, Middle, D CORBIN		urname)		
M	Maryland 21215-0036 12 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam		19a. Informant's Nam	ne/Relationship (	**			g Address (Street HANSON R	and Number or R	ural Route Numbe	er, City or T		ip Code)	
26	Baltimore,  bermit, Page 1 and Department of Hea Important: If item any injury or othe		20a. Method of Dispo	sition	☐ Removal from State	Ç	ace of Dispo emetery, cren	sition (Name of natory or other pla	ce)	Date	20c. Loc	cation - City or		
3	ti. Pag tmer tant tant jury	انه	4 Donation §	5 Other (Spec	rify)	ME		EMATORY,					E, MD HOME, P.A.	
20.	Dep Deri	ouce.	VA				8	521 LOCH	RAVEN E	LVD. TO	OWSON,	, MD 2		
1000054613	-∼ Ph, siciar , Medica	-	23a. Part 1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	failure. List only inal	nplications that caused one cause a each line a.	inor	na i	netoto	shi to	brain	rrest,		Approximate Interval Between Onset and Death	
4	Examine	er .		m .	Due to (or as	le t	ence of):	ned p	orima	3				
n	₩ _ isi	Examiner	if any, leading to imm cause. Enter Underly Cause (Disease or iir	nediate ving njury	Due to (or as	a consequ	ence of):	·		J				
à	s execution and unial-tra	al Exa	that initiated events resulting in death) La	nst	C. Due to (or as	a consequ	ence of):							
Tr.	68760 ertificate b ding physic				d									
15/	Division of Vital/Records, P.O. Box 68760 C.D. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent properties in the past 12 mm 1 ☐ Yes 2 ☑ 9 ☐ Unknown		23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су		2	3d. Date of de Month	elivery Day Year	
H	es that t signed b be deta			ant conditions	contributing to death b		ulting in the u		ven in Part I.	23e. Did t		1	o the cause of death?	
2	ords v requir	Completed by		0	) , ,		<u>·</u>			24a. Was	an	24b. Were au	utopsy findings available	
1	Rec The lav	Comp								auto perfo 1 □ Yes	ormed? 2 No	death?	completion of cause of	
2	Vital ysician: s certific director,	To Be	25. Was case referred examiner?  1 \sum Yes 2  \q	/	Hospital:	ont 2 🗆 I	ER/Outpatien	Oth	lace of Death (Cher:	eck only one)  Home 5 $\square$ Resi	danas 6 [	Other (Spec	516.4	
W.	n of \ ling Phy ling Phy After this		27. Manner of Death  1 Natural	5 Pending	28a. Date of inju (Month, Day	ry	28b. Time of injury	28c. Injur work	y at </th <th>28d. Describe</th> <th></th> <th></th> <th>sny)</th>	28d. Describe			sny)	
The	Division al or Attendir s after death. Il Director: Af	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not determined	be Diago of Inju	ury - At hor c. (Specify)	ne, farm, stre		Yes 2 No	28f. Location ( City or Tox		Number or Ru	ıral Route Number,	
1	Le Hospita n 24 hours re Funeral	Medical	(Check 2	Medical Exan	ysician: To the best of niner: On the basis of e	xamination	and/or invest	gation, in my opini	on, death occurred	at the time, date a	and place, a	and due to the	cause(s) and manner stated.	
4	To th within To th	-	29b. Signature and tit	le of certifier	2		MO	29c. Licens	e number る624	45	29d. Date	signed (Monti	h, Day, Year)	
•	10		30. Name and addres	s of person who	completed cause of d	eath (Item	23a) (Type, P	rint) 500 W	per U	Llsuper	Ju I	), B	2-12 e1 Air MD	
	S Regis	late trar	31 Operiles (Man 2	012 ear) Se	32. Registra	ar's a gnath	es es		1	<u> </u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death 2. Date of Death SK October Physician/ WAYD aves Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner enter och Kaven Community LIVING 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) Director 213-30-3215 1 XM 2 🗆 F 78 MD 11 16 33 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore NA MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21207 6747 Brookmont Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 14. Race - American Indian. Black, White, etc. or. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify. Black Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5yrs+ 12th grade Long and Foster Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Evelyn Hayes Cornelius Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6747 Brookmont Drive, Baltimore, Md Md 21207 Jean Hayes-Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ Other (Specify) injury ( 10/12/02/12 Owings Mills, Garrison Forest Vet 22. Name and Address of Facility March F/H West 21. Signature of Juneral Service Lightse 21215 Baltimore, Md 4300 Wabash Ave, 23a. Part 1. Egyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Approximate Approximate Interval Between Interval shock, or heart failure. List only one cause on each line. Immediate Cause (Final arcinoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence HUSPICE Hospital: 2 1 No မ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 🔲 No 2 Accident Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, JX. 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) 3900 Raven oule 244 21218 TROVAR move au 0 31. Date filed (Month\_Day, Year) State rack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20/2 3:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Izabeth en. N/A 24 Hrs. Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 □ M 2 🗙 F Months Hours Country) 77 243-46-8215 Director N.C Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2 No Baltimore MD Rosedale 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a or Funeral 1519 Chapel Hill Drive 21237 12. Was Decedent Ever in U.S. Armed Forces?.

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 X Widowed 4 Divorced Year or Dates Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. event, the Homemaker 12th Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Whitaker Hattie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Davis-Daughter Hill Dr. Rosedale. Chapel MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 
Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) Pk.10/12/2012Randallstown, MD Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East a randon Millain 1101 E. North Ave. Baltimore, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mcer Physician/ + 03 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi ens that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760  $\zeta$ Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 Wo
9 Unknown Month Year Day Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 X No 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Other: 욘 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending work' 1 Tes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and use to the sease(s) and maintened stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time date and place and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) venue 31. Date filed (Month, Day, Yea State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Faith Hepburn Clara Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard 7810 Clark Road Unit E-17 Jessup Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) **Director** 217-26-2018 1 🗆 M 2 💢 F May 6, 1931 Maryland Usual Residence of Decedent show 10b. County 10a, State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Marvland Howard Jessup 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20794 7810 Clark Road Unit E-17 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. δ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 V Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mexicology. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Eldercare Private Duty Care Giver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles | Jenkins Rhodes Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Pappas (Daughter) 610 Sutton Drive Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 10/12/2012 Elkridge Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MOO-732 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter under light Examine Don'to for as a nonsequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) OM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie MD2106 SRIDHAR, ATIURI 7310 Ritchie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jay Fleddinger		I- For State Registrar	tate of Maryland		icate of		ia ivicii	arriygic		g. No.	201	2 3240
Physicia		Decedent's Name (First, Midd	dle,Last)						ate of Death	n Day	Year	3. Time of Death
Medical Examin		Jay Will		linger_				Od	ctober 8,	2012		1152 hrs
*		4a. Facility Name (if not instituti 2906 Bauerwood Ave	. •	r)	4	b. City, Town, o Baltimore	r Location o	of Death		4c. Co	unty of Death	1
Funeral	4	Social Security Number		.ge (In yrs. last I	birthday)	If Under 1 Yes	ar If Unde	er 24Hrs.   8.	Date of Birth	h(MM/DD/	YYYY) 9. Bir	thplace (State or Foreign
Director		215–48–0129	1XXM 2 F	50	Yrs.	Months Day		Min.	8/5/19	962		untry) aryland
	L	Usual Residence of Decedent			,							
w any		10a. State 10b. County	,	10c. City, To		on						10d. Inside City Limits  1 Yes 2 X No
yland -f sho	ģ	Maryland		Balti	more	10f. Zip Code			1 10	a Citizen	of What Cou	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "matural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	2 -							J. S.		indy.
with the ns 23a		2906 Bauernwood 11. Marital Status	12. Was Decede			21224 Decedent of H			Yes or No-		Race - Amer	ican Indian, Black,
death r iten	Funeral	1 Never Married 2 N	Married Armed Force	s? 2 <b>X</b> No		es, specify Cuba			n, etc.)		White, etc.	
after	Ð.		ivorced If Yes, Give Year or Dates:			Yes 2 X N			Jama		of Business	/hite
hours natur		<ol> <li>Decedent's Education (Sp Elementary/Secondary (0-12</li> </ol>			during mo	's Usual Occupa est of working life	e. DO NOT	use retired)	JOI IE		iting a	,
136 hin 72 e. than	Completed	Liene hary/3000 haary (0 12	2		Sales	man					_	tioning
5-00 ed wit lygien other he Ma	녌	17. Father's Name (First, Middle	e, Last)		burce		18.Mother	's Name (Firs	t, Middle, N			
215 be fill mtal H rked	Be	John H. Heddi	nger				Hele	en J. (	Clark			
Should Me is ma	ို	19a. Informant's Name/Relation		153		Address (Stre						
Baltimore, MD 21215-0036 ormit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than rightry or other traumatite event, the Medical		Elizabeth Hede 20a. Method of Disposition	dinger (Daug			Brighton tion (Name of co		CE ES		Mary 1 20c. Loca	and 21	ZZI Town, State
Ore ges 1: fof H			on 3 Removal from	State	matory or oth	' '	•	40/0/	2010	_ ,		
ltimen ritmen y or o	-	4 Donation 5 Other 5		Bay	22. N	Cremato: ame and Addres	s of Facilit	y				Maryland
Baltimore, MD 2 pernit. Pages I and 2 shoul Department of Health and Iv Important: If iten 27 is m injury or other traumatic.		127. 1.1	03.11	50	P <sub>4</sub>	uzdzins	ki Fu Easte	neral rn Ave	Home ]	PA Essex	. Mary	rland 21221
Physician	T	23a. Part I. Enter the disease, of failure. List only one cause	or complications that cause	ed the death. Do	not enter th	e mode of dying	g, such as c	cardiac or res	oiratory arre	st, shock,	or heart	Approximate Interval Between Onset and
Medical   Examiner	1	Immediate Cause (Final diseas	se a. Hypertensive	Atheroscler	otic Cardi	ovascular D	isease					Death
_xammor		or condition resulting in death)	Dao 10 (01 do d 00.	nsequence of):								
	<u>ē</u>	Sequentially list conditions, If any leading to immediate	b. Due to (or as a cor	nsequence of):								
	Medical Examiner	cause. Enter Underlying Caus (Disease or injury that initiated	C.	nsequence of):	<u> </u>							
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760, icate be physic the bur	/Ne	IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, outc			tal death 3	Ectoni	c pregnancy		-	ate of delive	y Day Year
certife ending	cian	past 12 months?	LIVE DITAL	at time of death		tal death 3 ner (Specify)	Lotopi	c pregnancy		1	71111	Say
Records, P.O. Box 68760, The law requires that the death certificate be care has been signed by the attending physici page 2 should be detached for use as the burn	Physician/I	1 Yes 2 No 9 U	9 OTKHOWII									
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ician:	å	25. Was case referred to media examiner?	Tite a side is	atient 2 Ef	R/Outpatient		Ce of Death	(Check only Nursing Ho		Residence	e 6 🗸 Oth	ar: Scene
of Vi	<u>د</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of I (Month, Da		8b. Time of I		jury at Worl		. Describe			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	1 V Natural 5 Pe	ending	y,Year)		1	Yes 2	No				
IVISION or Attend after death. Director:	ifica	3 Suicide 6 Co	ould not be	f Injury - At hom	e, farm, stree	et, factory, office	building, e	etc. 28f.	Location (S		Number or R	ural Route Number, City
Di spital nours a neral I	Cert	4 Homicide	termined (Specify)									
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying one) 2 Medical Ex	Physician: To the best of xaminer: On the basis of e	f my knowledge, xamination and	, death occur /or investigat	red at the time, tion, in my opinio	date and pl on, death o	lace, and due ccurred at the	to the caus time, date	e(s) and n and place	nanner as sta , and due to t	ited. he cause(s)
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1		Churc	Hallo	2012		0.0	C.M.E.			Octob	er 9, 2012	y v.
101/4		30. Name and address of person	on who completed cause of	of death (Item 23	 3a)							
( 0		Carol H. Allan, MD	Assistant Medical	Examiner	900 W. E	Baltimore St	reet, Bal	timore, MI	21223			
	ate	31. Date filed (Month, Day, Yea	32. Regis	trar's Signature	and I							
Regist		<u> </u>	- person	- C	ORIGINA							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifica	ate of	Death			F	Reg. No.	21		2 3241
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) Keith A. Hall							Date of De Month October	Day 4, 201			3. Time of Death 2229 hrs
		4a. Facility Name (if not institution, give stre St. Agnes Hospital				Baltimore			_		c. County of		
Funeral Director		5. Social Security Number 218-70-0036 6. Sex		yrs. last birtl	hday) Yrs.	If Under 1 Ye			8. Date of B 5/31/		1	Carain	hplace (State or n Intry) MD
Aaryland 28a-f show any 1.at once.	or	Usual Residence of Decedent  10a. State  MD  10b. County	10c.	City, Town	or Locatio								10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 5462 Maplewood Driv	e			10f. Zip Code 21229				10g. Citi	izen of Wha	at Coun	try?
after death wi	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced If the or B	ates:	No	If Ye	Decedent of H s, specify Cuba res 2 N				0-	14. Race - White, Specify:		an Indian, Black, te
7	Completed t	15. Decedent's Education (Specify only his Elementary/Secondary (0-12)	ghest grade complete College (1-4 or 5+)	<b>-</b>   '		s Usual Occup st of working lif er					Kind of Bus Weldi		ndustry
MD 21215-0036 1.2 should be filed within 7 th and Mental Hygiene. 1.27 is marked other than umatic event, the Medica	Be	17. Father's Name (First, Middle, Last) Richard Eugene Hal					Mild	lred I	irst, Middle, . Cor	nece	elli		
MD 21 od 2 should tith and Me m 27 is ma	٢	19a. Informant's Name/Relationship (Type, Sarah B. Hall/daugh	ter	39	10 B	Address (Stre lackbui	n Lan	e #14	Burt	ons	ville	MD	20866
Baltimore, MD 2 pernit. Pages I and 2 shou Department of Health and M Important: If item 27 is n injury or other traumatic		20a, Method of Disposition  1 Burial 2 X Cremation 3 R  4 Donation 5 Other Specify:			Crer	natory		10/1		Ca	Location - (	ill	e MD
		21. Signature of Funeral Service Licenses  23a. Part I. Enter the disease, or complication		01364	421		Hwy S	E Gle					Approximate Interval
Physician /Medical ====================================		failure. List only one cause on each lir Immediate Cause (Final disease a. A1		Narco					spiratory ar	1651, 5110	ock, of flear		Between Onset and Death
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Box 68760, edeath certificate be the attending physicied for use as the buri	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown g	c. If yes, outcome of Live birth Pregnant at time Unknown	pregnancy 2	Feta	death 3		: pregnancy		230	d. Date of d Month	elivery Da	ay Year
P.O. Be es that the de igned by the be detached f	è	Part II. Other significant conditions cont	ributing to death but	not resulting	in the un	derlying cause	given in Pa	rt I.			_	_	ne cause of death?
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 X Could not be determined	fd 10-4-12 28e. Place of Injury - (Specify) Town			factory, office	building, etc			State)4	562 Ma		al Route Number, City
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J. W. W. W. D.	Me	29b. Signature and title of certifier  Covar Hali	Dan			29c, Licen	se number			1	Date signed ober 5, 2		th, Day, Year)
$\phi$		30. Name and address of person who compl Carol H. Allan, MD Assistan	eted cause of death		0 W. Ba	ıltimore Str	eet, Balti	more, M	D 21223				
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ <sup>Year</sup>12 Richard Lewis Hill, III 12:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 819 Fairway Drive Baltimore Towson 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. (Month 6/30) 1943 Country) lorado 69 510-44-0482 Director 1 1 M 2 1 F 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 ☐ No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 319 Fairway Drive 21286 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Pipefitter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Richard Hill Dorothy Neiman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah W. Bedwell / Wife 819 Fairway Drive, Towson, MD 21286 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/10/2012 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall \ Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Pancreatic Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last certificate has been signed by the attending physician lirector, page 2 should be detached for use as the burla Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Multiple Myeloma 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a, Was an performed? Yes 2 No ours after death, eral Director, After this certifics filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: Other: 4 Nursing Home 5 MResidence 6 Other (Specify) 2 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a
To the Funeral I
completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the bes or my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatu 29d. Date signed (Month, Day, Year) D 29373 October 10, 2012 who complete cause of death (Item 23a) (Type, Print) Eric J. Seifter, MD 10755 Falls Road, Suite 200, Lutherville, MD 21093

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 8-35A M ORENZ USEMAN 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Augsburg Lutheran Home Catonsville If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral **Director** 484-16-3852 1**X**□ M 2 □ F 99 November 1,1912 Iowa Usual Residence of Deced show or 28a-f shov e notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛣 No Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? č of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 21222 203 St. Helena Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc þ 1 X Never Married 2 ☐ Married 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Assembler Martin Marietta 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clara List William Huseman 1 and 2 should be the Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 Foxhall Road NW, Washington DC, 20007 Darren Womer grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot October 9. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Sacred Heart of Mary Ceme. 2012 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Conneity Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate DISEASE Onset and Death PULMONARY Immediate Cause (Final STRUCTIVE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 2 No tor: After this certificate has been signed by the arthefuneral director, page 2 should be detached 9 Unknown 9 Unknown P.0. Part Ju Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RUTHMIAS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24a. Was an 24b. Were autopsy findings available prior to completion of death? autopsy Yes 2 1 Yes Division of Vital Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 2 No Investigation 1 Yes Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 2 28595 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DWINGS 1525 MILL AICHANI HSNEEM O 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>Yea</sup> 2:20pm M October 8, Huster Carroll Tracey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Manchester Long View Nursing Home 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Days Hours Director 215-44-1099 1 X M 2 T F 93 Feb. 16, 1919 MD Usual Residence of Decedent 28a-f show should be filed within 12112...
and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-1 5...
7 is marked other than Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 Yes 2 No Manchester Carroll 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 21102 Roller 5020 Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 Yes 2 No Specify If Yes Give 3 Widowed 4 Divorced White Completed Year or Dates WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4 or 5+) Assistant Postmaster Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcella Tracey Department of Health and Menti Important: If item 27 is marked any injury or com-Carroll Ε. Huster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Manchester, MD 21102 5020 Roller Road (son) Jeffrey B. Huster Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10-17-2012 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. ELINE FUNERAL HOME 22. Name and Address of Facility Signature of Funeral)S 11824 Reisterstown Rd. Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last ettendi g physician for use as the buria Physician/Medical de th certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Dav Pregnant at time of death 1 Yes 2 9 Unknown 2 No Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires to thours after death. Funeral Director: After this certificate has been sign 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No 1 🗌 Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 🛕 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tes 2 No Accident
Sulcide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51705

IDTI

State Registrar 31. Date filed (Month, Day, Year) 32 hagistrar's Signature OCT 1 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malcolm

DR

Westminster

			Please	Type or Print in I AMEND ITEM#51 State of Marylan	Black in perFH, d/Depa	<b>delible In</b> 3932, 107 artment of F	<b>k. Ensure</b> 15/2012, Health and	All Copies	s Are	Legible	2 32412
			1 - State Registrar	•		tificate of L			Reg. No.	201	2 32412
	". Disease i sei s	,	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ath	.,	3. Time of Death
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	Examir	ner	4a. Facility Name (if not institution, give				r Location of Deat		4c.	County of Dea	ath
	Funeral Director		210-42-3762	PXM 2 $\square$ F 7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day	h Year) G=19	9. Bi	rthplace (State or Foreign buntry) Carolina
	Ba-f show	Director	Usual Residence of Decedent  10a. State 10b. County	10 N	Town or Loc						10d. Inside City Limits 1  Yes 2 □ No
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36	anough be lied within 72 hours after death with the waryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	If	Vas Decedent of H Yes, specify Cuba	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		4. Race - Ame Black, Whit	
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Maryland	f Health and Mental item 27 is marked o other traumatic eve	-	Myers Joh	14504	-		Hel			rvivs.	
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om!	. 0		1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	emetery, crem	natory or other place	ce)	4-2012			·
Baltimore,	Department Important: I any injury o		21. Signature of Funeral Service Licens	1,16	22.	Name and Addre	ss of Facility	4611	Park	iteigh	ts Are
m i			Limoest	C. Jones	- Th	e Demok	C. Jones	EH.P.A	B	- Itimo	re, Md. 21215
	nysician/ Medical xaminer		23a. Part 1. Enter the disease, or come shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	ne cause on each line.  Non-Smal  Due to (or as a consequence)							Approximate Interval Between Onset and Death
De executed		cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter Unidentity Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)							
. Box 68760	been signed by the attending physici	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar  1	I death 3 🗌	Ectopic pregnanc Other (specify)	sy		2	3d. Date of de Month	olivery Day Year
O. H	ned by	by Pł	Part II. Other significant conditions of		ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?
dS,	en sig	ed	MYELODYS	PLASIA			-	1 🗆 🗅	Yes 2	No 3 ₩	Probably 4 🗆 Unknown
DIVISION OF VITAL RECORDS, P.O	ate has be	Completed						24a. Was a autop perfor	rmed?	prior to death?	utopsy findings available completion of cause of
	ertifica ector,	Be	25. Was case referred to medical examiner?				ace of Death (Che				
Shysi	this c al dire	은	1 Yes 2 No 27. Manner of Death	Hospital:  1  Inpatient 2  I			4 Minursing F	lome 5 Resid			cify)
ion o	within 24 hours after death.  To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	(Month, Day, Year)	28b. Time of injury			28d. Describe h			
DIVIS	urs after ral Direc		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		_		City or Tow	n, State)		ıral Route Number,
Hosp	24 hore	ledical	(Check 2 Medical Exami	sician: To the best of my knowle iner: On the basis of examination	and/or investi	gation, in my opinio	on, death occurred	at the time, date ar	nd place, a	and due to the	cause(s) and manner stated.
To the	within <b>To th</b> e соттр!	Σ	29b. Signature and title of certifier	se Practioner: To the best of my	MIOWIEG9E, di	eath occurred at the 29c. License				and manner as signed (Monti	
	0		> Bhavnet k	au		1000	73575			12/12	
			30. Name and address of person who o	completed cause of death (Item	23a) (Type, Pr	rint)	· · · · · · · · · · · · · · · · · · ·				
			Bharneet Bh	argj 8813	wa	Ltham 1	ucodi	ed suit	1#2	oy. Pa	rku. UL MO-212
	Star Registra		31. Date filed (Month, Day, Year) 2012	32. Registrar's Signatu	are fact						rku. UL MO-212

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Kevin Tramaine Jones	State of Maryland / Department of Health and Mental Hygiene	20	2	324	1
1- For State	Cortificate of Dooth	20		064	l.

		1- For State Registrar		Certific	ate of D	eath		R	eg. No.	OIL OLT
Physici		Decedent's Name (First, Midd	dle,Last)					2. Date of Dea	ith	3. Time of Death
Medical Exami		Kevin Tram	aine Jones	5				Month Septemb	Day Year er 28, 2012	1450 hrs
		4a. Facility Name (if not instituti			4b. (	City, Town, or L	ocation of		4c. County of D	
		2416 N. Calvert Stree				altimore			N/	
5		Social Security Number		(In yrs. last birt		Under 1 Year	If Under:	Odles O Data of Di		
Funeral Director		unknown		(III yrs. last bill		Months Days	Hours	Min.		). Birthplace (State or oreign
Director			1 M 2 F	3	8 Yrs.				/1973	Country)NY
		Usual Residence of Decedent								
any		10a. State 10b. County	ľ	10c. City, Town	or Location					10d. Inside City Limits
pu pu	-	MD N/	A	Baltin	nore					1 X Yes 2 No
Aaryland <b>28a-f show</b> Lat once.	ctc	10e. Street and Number			10	f. Zip Code		17	0g. Citizen of What	Country?
ith the Maryland 23a or 28a-f sho notified at once.	Director	2416 N. Calv	ert St. 3rd	Floo	r	2121	8		USA	•
ith th 23a noti	ral	11. Marital Status								
th w	Jer	1 Never Married 2 N	12. Was Decedent E Armed Forces?	ever in U.S.				? (Specify Yes or No uerto Rican, etc.)	14. Race - A White, e	merican Indian, Black, tc.
r dea or ii	Fune		1 Yes 2	No		(C-21)				
afte	þ	]	vorced If Yes, Give Year or Dates:			2 X No				Black
215-0036 be filed within 72 hours afte ntal Hygiene. -ked other than "natural", ent, the Medical Examiner		15. Decedent's Education (Spe				Isual Occupation of working life. [		nd of work done	16b. Kind of Busine	ess/Industry
721	Completed	Elementary/Secondary (0-12)		+)	•		) ( ) ( ) ( ) ( )	o retired,		
Sed it it in	Ę	12th	2yrs.	La	abore:	r			Various	Jobs
ed w ed w	ပိ	17. Father's Name (First, Middle	, Last)			18	3.Mother's	Name (First, Middle,	Maiden Surname)	
215-0036 be filed within 7 and Hygiene. rked other than ent, the Medica	Be	William Jon	es			0	ora	Fisher		
ID 21215-00; should be filed withing and Mental Hygiene, 77 is marked other than	2	19a. Informant's Name/Relation:	ship (Type, Print )	198	. Mailing Add			er or Rural Route Nur	nber, City or Town, S	State, Zip Code)
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once		William Jone	s-Father	119						
e, MI 1 and 2 s Health a		20a. Method of Disposition	D I d CIICI	20b. Place o	of Disposition	(Name of ceme	eterv.	Date	20c. Location - Cit	n NY 11207 ty or Town, State
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Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr		21, Signature of Funeral Service	Licensee	1	22. Name	and Address o	of Facility	March E	'/H-East	
E E A B CO		Minette	K. Jones		1110	1 E. N	orth	Ave. Ba	ltimore	, MD 21202
Physician		23a. Part I. Enter the disease, or	r complications that caused the	he death. Do no						Approximate Interval
Medical		failure. List only one cause		Pilma	-3 -					Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Myocardial  Due to (or as a consec		STR					
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	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):						
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3760, ficate be g physicist the burn	š	IF FEMALE:	23c. If yes, outcome	e of pregnancy					23d. Date of del	ivery
mg p	3	23b. Was decedent pregnant in t past 12 months?			Fetal d	eath 3	Ectopic p	regnancy	Month	Day Year
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Box 68 e death certi the attending ed for use as	ys	1 Yes 2 No 9 Un	known 9 Unknown						-2371	
P.O. Box 68 that the death certif ned by the attending detached for use as		Part II. Other significant condi	tions contributing to death	but not resulting	in the under	lying cause giv	en in Part	I. 23e, Did to	bacco use contribut	e to the cause of death?
P. S this so this gned	۾	Ketoacidosis	; Liver fibro	sis and	l proba	able fa	ttv 1	iver 1 Yes	2 No 3	Probably 4 🗹 Unknown
Division of Vital Records, P.O. fall or Attending Physician: The law requires that it is after death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed	· -						24a. Was	an 24b Wen	e autopsy findings available
Ore aw re has be 2 sho	륍							autop	sy prior	to completion of cause of
Rec The li	티							1 <b>✓</b> Yes	rmed? deat	Yes 2 No
tal Re tian: The certificate ector, pag		25. Was case referred to medica	al learning			26.Place o	f Death (Cl	heck only one)		
/stcis ce direc	Be C	examiner?  1 Yes 2 No	Hospital: 1 Inpatien	t 2 ER/O	utpatient 3	DOA O	ther <sub>4</sub>	lursing Home 5	Residence 6 🗸 0	ther: Scene
ision of Vital Rec Attending Physician: The r death. ector: After this certificate by the funeral director, page	2	27. Manner of Death	28a. Date of Injury	y 28b. 1	Time of Injury	28c. Injury			now injury occurred	
i. Af	등	1 X Natural 5 Pen	(Month, Day,Yes	ar)		1 □ Ye	s 2 N	1	.,.,.	
SiO deat deat y th	[at		stigation					A44		
d in t	. <b>\$</b>		ld not be 28e. Place of Inju	ıry - At nome, ta	rm, street, ta	ctory, office buil	lding, etc.	28f. Location (S		r Rural Route Number, City
DIVI spital or or or or or or safter acral Direction of tilled in I	Certification:	4 Homicide	ermined (Specify)							1
등 등 등 등 의			hysician: To the best of my							
To the Hos within 24 h completely	Medical	one) 2 Medical Exa	miner: On the basis of exam and manner stated.	ination and/or in	nvestigation,	in my opinion, d	leath occur	rred at the time, date	and place, and due t	to the cause(s)
FRES	Ψ	29b. Signature and title of certification				29c, License r	number		29d. Date signed	(Month, Day, Year)
a		MAISTO				O.C.M.	.E.		September 29	
Onno		WWE DC				3.3.1			300.000.20	.,
Ox be		30. Name and address of persor			000 144	Dallin 1	34mm or 4 . 72	-14	222	
		Ana Rubio M.D., Ph.			900 W.	Baitimore S	street, B	aitimore, MD 21	223	
	tate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	11					
Regist	trar	OCT 1 0 2012	Charles A.	par	*					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCHORDA 10:15 PM 2012 DI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Chirles olcente, A Howeve 5. Social Security Number 216-28-7013 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Hours Min. **Director** Usual Residence of Decedent or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Howard 1 Yes 2 No 10e. Street and N 10f. Zip Code 10g. Citizen of What Country? Funeral IJSA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) chnician Be Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) a cemetery, crematory or other place 21. Signatur / f Funeral Service Licensee 22. Name and Address of Facility for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DancestiA disease or condition DOWS Medical resulting in death) Examiner 40curs LOUSIOD DOR Sequentially list conditions. Examine Due to (or if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury as a consequence of) attending physician and for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CanocaR. To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Tes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **M** No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) RO51063 Mauren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 hoch Raven Blod Mauros Kell

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Shirley M. Jackson 2013 0 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Franklin Rosedove Square Hospita Baltimore 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Maine Hours August 10,1928 **Director** 007-22-6703 1 🗆 M 2 🗶 F 84 Vrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 must be i by Funeral 1900 Grove Manor Drive # 205 21221 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item edical Examiner r 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 27 is marked other than "natur r traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Mental Hygiene. 8 Lever Brothers Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George McCallum Mary Boudreau 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Denise VanValkenburgh/Daughter 33 LLoyd Avenue Malvern, PA 19355 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State Bayview Crematory 10/08/12 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Connelly Funeral Mace Home Avenue Balto. M of Essex 21221 MD. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. multionsan Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions if an leadin to immediate cause. Enter Underlying Cause (Disease or injury Exami as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' 2 No 1 Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

**φ√** State

Registrar

DHMH 17 Rev 06-2011

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

masou

Year,

D006329

canklin Square Drive Baltimore MD

112

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5-2012 Emma Jones 11:43 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7315 Geise Avenue Baltimore Edgemere Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days 217-22-0358 Hours Director 86 1 □ M 2 🗓 F Sept. 25,1926 Md. item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Edgemere 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 USA 7315 Geise Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs. Acrobat Stage 1 vr. Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic events. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Emma E. Voge I Charles Earl McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7315 Geise Ave. Edgemere Md. 21219 Beth A. Jones daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. Date, 2012 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Bayview Crematory of Funeral Service Licenses 21. Signature 22. Name and Address of Facility Connelly Funeral Home of Dundalk, PA 7110 Sollers Point Road Dundalk, MD 21222 23a. Parv1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Weeks Immediate Cause (Final Congestive heart failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical Records, P.O. Box 68760∢ 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Obstructive 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ce 29c. License number D 0032548 October 5,2012 Johns Hopkins Bayview Medical Centers signature Name and address of person who completed cause of death (Item 23a) (Type, Print) \ d OLVIN MD 31. Date filed (Month Day Year) State Registrar

DHMH 17 Rev 06-2011

**Division of Vital** 

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760528

	_	1 - For State Registrar			d / Depa	idelible Inkartment of H tificate of E	ealth and I	Mental Hy	giene Reg. No.	-egible. 2012	2 32417	
Physicia /Medic Examin	al	Decedent's Name (First, Middle,	give street and number)			4b. City, Town, or	Location of Death	2. Date of De Month	Day	Year  20\  County of Deat	3. Time of Death  (O:25 A M	
Funeral Director		Johns Hopkins Bays 5. Social Security Number 235–22–7371  Usual Residence of Decedent		Center ge (In yrs. la 89		Baltimore  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D.	ay, Year)	Co	thplace (State or Foreign untry) st Virginia	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	rector	10a. State 10b. County  Maryland Balti  10e. Street and Number	more	10c. City	, Town or Loo Dur	ndalk			10g, Citize	en of What Co	10d. Inside City Limits 1  Yes 2 No	
fter death with ir items 23a o iner must be	Funeral Director	7264 Conley Stre  11. Marital Status  1 \( \text{Never Married} \) 2 \( \text{Married} \)	12. Was Decedent Armed Forces? d 1 \sum Yes 2 \sum 2		l l	Was Decedent of Hi	n, Mexican, Puerto	pecify Yes or No Rican, etc.)	U	SA 4. Race - Ame	A Race - American Indian, Black, White, etc.	
nin 72 hours a n "natural", o Aedical Exam	Completed by	3 XWidowed 4 Divorced  15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	16a. Deced	I ☐ Yes 2 🔏 No dent's Usual Occupa kind of work done o DO NOT use retired	luring most of wor	king		Specify: W		
id be filed with ental Hygiene ked other tha c event, the it	e	12 years 17. Father's Name (First, Middle, La Ray W. Watkins			Ноц	usewife	18. Mother's Nar		e, Maiden S	Home Surname)		
1 and 2 shou Health and M em 27 is mar ther traumati		19a. Informant's Name/Relationshi Susan Alafriz 20a. Method of Disposition	p (Type. Print)  Daughte	_	2813	ng Address (Street a	h Road, 1	Dundalk	, Mar		21222	
permit. Pages Department of Important: If it eny injury or o once.		1 ☐ Bunal 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Service Lie) 21. Signature of Funeral Service Lie	ecify)	Ce	Lawn	Cemetery  Name and Address	11,	ober 2012 ome of	Balt:	imore,	Maryland	
Physician		23a. Part 1. Enter the disease, or conditions that the disease or condition	omplications that caused the one cause on each line.	ne.	Do not ent	or the mode of dyin	rs Point g, such as cardiad	Road,	Dunda. arrest,	lk,Mar	yland 21222 Approximate Interval Between Onset and Death	
/Medical Examiner	ner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	vence of):	Pelmoor	J Disea	×				
be executed sician and burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	uence of):								
To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the total states.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outcome 1	2 🗌 Fetal	death 3	Ectopic pregnancy	,		. 23	3d. Date of de Month	livery Day Year	
w requires that the death been signed by the atter should be detached for	þ	9 Unknown  Part II. Other significant condition		but not resu	ulting in the u	underlying cause gi	ven in Part I.			se contribute t	to the cause of death?	
in: The law re lificate has bee tor, page 2 sho	e Completed	25. Was case referred to medical					26. Place of Dea	perf 1 ☐ Yes	ormed? 2 No	prior to death?	utopsy findings available completion of cause of	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2	To B	examiner?  1  Yes 2  O  27. Manner of Death  1 Natural 5  Pending  2  Accident investigat	Hospital: 1 Inpati	ury	ER/Outpatien 28b. Time o Injury	f 28c. Injun Work	er: 4 □ Nursing H	ome 5 Res	sidence 6		cify)	
pital or Atten ours after dea eral Director. filled in by the	Il Certification:	3 Suicide 6 Could not determine	and Zoe. Flace Utili	tc. (Specity	")	eet, factory, office	ne, date and place	City or To	wn, State)		Rural Route Number,	
To the Hos within 24 h To the Fun completely	Medical		Examiner: On the basis of and manner s	of examinat tated.		vestigation, in my o	pinion, death occ		e, date and 29d. Date	place, and du	th, Day, Year)	
10			Michelle,	death (Iten				Eastern A	00.0	, Baltim	ore, MD, 21224	
Sta Registr IMH 17 Rev 1/20	ar	31. Date filed (Month)—Day, Year).  OCT 10	2012 Arm	rar's Signat		ald		***************************************				

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Roland P. Kaline October 2012 2:09a 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 822 Chatfield Road Harford Joppa Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) Director 80 216-28-9537 1 **X** M 2 □ F 27,1932 MD January ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Harford Joppa MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21085 USA 822 Chatfield 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2: ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", 3 X Widowed 4 Divorced Specify: White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) GM 11th ineworker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Bryan E. Kaline Lydia A. Wholley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .02 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Linda Cannon (Daughter) Chatfield Road Joppa, MD 21085 822 Important: If item any injury 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 10/13/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Essex 300 Mace Ave. Baltimore, MD 21221 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician ayamous Cell disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** > 10 years Vivonic Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to the as a consequence of Exami law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 109/12 40055992 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 Baltimore 6 Gallo Holsbird MD 31. Date filed (Month, Day, Year) State Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G933, 11/1/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Day 07 Monta 10 2012 1426 Cindy Lee Long Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Harford Havre de Grace Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1962 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 🛣 Hours 213-88-6956 Country) 10709/<del>2012</del> Director Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Me. 1. Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Maryland Harford Aberdeen 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 123 Rock Road 21001 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 XXNo Black, White, etc. should be filed within 72 hours after a and Mental Hygiene.

is marked other than "natural", or 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 House wife In home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hawks Burlie Paul Hamm Gladys Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Deborah S. Marshall (sister) 51 Doctor Jack Road, Port Deposit, MD 21904 permit, Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Company | 10/10/2012 West Chester, PA 21. Signature of Funeral Service icensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or compile: tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ NOXIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner TASTATIC Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Year Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Certificate: To Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9118 Name and address of person who completed cause of death (Item 23a) (Type, Print) Puthawala Houre de Grece, MD 601 Revolution Street State I 0 2012 Registrar

Elliot Ross Lee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK	1	Stat	te of Maryland		irtment of <i>tificate of</i>		and	Menta	al Hy		2 N.	21		2 324	2
Physician		<b>Registrar</b> 1. Decedent's Name (First, Middle,L	_ast)		tinoato oi	Douin			2	. Date of De		Von		3. Time of Death	<u></u>
dedical Examin	er	Elliott Royce						_		Month Septemb				0330 hrs	
>	•	4a. Facility Name (if not institution, Johns Hopkins Hospital		r)	1	4b. City, To Baltimo		ocation of	Death		40	. County o	t Death		
Funeral				ge (In yrs. la	ast birthday)	If Under		If Under	24Hrs.	8. Date of B	irth (MM/	DD/YYYY)	9. Birt	hplace (State or	
Director	- 1	-11 06 0515	IX M 2 F	28	Yrs	Months 3.	Days	Hours	Min.	05/0	8/19	984	Foreig Cou	n Marylar <sub>untry)</sub>	ıd
	E	Usual Residence of Decedent													
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Maryland 28a-f shuw d at once.	흱	10e. Street and Number		Dai		10f. Zip 0	ode				10a. Citi	zen of Wh	at Cour		
th the Maryland  23a or 28a-f sho notified at once.	Director	1705 Lanvale	Street			212					USA			•	
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rs after	<u>a</u>	3 Widowed 4 Divorce  15. Decedent's Education (Specify	ced If Yes, Give Year or Dates: v only highest grade co	ompleted)	1 16a. Deceder	Yes 2 nt's Usual 0			nd of wo	rk done	16b. ł	Specify: ] Kind of Bus			
72 hour	를 -	Elementary/Secondary (0-12)	College (1-4 or		during m	nost of worki	ng life. D	OO NOT u	se retire	d)					
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JD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumaite event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, La Elliott R.Lee								First, Middle, Holm		Surname)			
212 all be Menta Menta mark	ш.	19a. Informant's Name/Relationship			19b. Mailin	g Address				ral Route Nu		ity or Towr	n, State	Zip Code)	
MD d 2 shoulth and m 27 is		Theresa Holme	s/Mother	1										MD.21223	}
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is in injury or other trausistic	П	20a. Method of Disposition  1	3 Removal from 5	State	Place of Dispos crematory or ot	her place)				Date	ļ		-	Town, State	
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Physician	十	23a. Part I. Enter the disease, or confailure. List only one cause or		ed the death	. Do not enter t	the mode of	dying, s	uch as car	diac or	respiratory a	rrest, sho	ock, or hea	art	Approximate Inter Between Onset a	
Examiner	1	Immediate Cause (Final disease	a. Gunshot Wour											Death	
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Box 6876C death certificate he attending phys of for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outc	ome of preg		etal death	3	Ectopic	pregnan	су	23	d. Date of Month		y Day Year	
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of Vital Records, P.O.  In Physician: The law requires that the three this certificate has been signed by neeral director, page 2 should be detach	9									1 🗌 Y	es 2	<b>/</b> No 3[	Prob	pably 4 Unknow	m
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Division tal or Attendi rs after death. al Director: /	Ę	2 Accident Investig	28e Place of	Injury - At h	ome, farm, stre	et, factory,	office bu	ilding, etc.	.	28f. Location or Town,		and Number	er or Ru	ral Route Number, (	City
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		29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of iner:On the basis of ex	my knowled kamination a	lge, death occu and/or investiga	irred at the tation, in my	ime, dat opinion,	e and plac death occ	ce, and ourred at	due to the ca the time, dat	use(s) ar te and pl	nd manner ace, and d	as stat lue to th	ed. e cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month WALTER M. MYERS, JR. 2:18 A.M OCTOBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death STELLA MARIS NURSING HOME TIMONIUM BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs, last birthday) 8. Date of Birth Hours (Month, Day, Year) Director 1X M 2 D F 212-20-2534 86 6/12/1926 MARYLAND show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 XNo MD BALTIMORE BALDWIN 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4907 HORSE HILL ROAD 21013 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural". Completed 3X Widowed 4 ☐ Divorced Year or Dates. WWII Specify: WHITE or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lin and Mental Hygiene. In and marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) MONUMENTAL LIFE 12TH GRADE INSURANCE SALESMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WALTER M. MYERS CATHERINE STURM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is SHIRLEY PREISSLER/DAUGHTER 4907 HORSE HILL ROAD BALDWIN, MD 21013 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place)
DULANEY VALLEY MEM. injury 10/11/2012 COCKEYSVILLE, MD 4 Donation 5 Other (Specify) CAPDENS 21. Signature of Euneral Service Licensee MOO2 1 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ind Physician. bstructive MONavy disease or condition Medical resulting in death) Due to (or as a cons y uence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA → Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Certifical Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ctober 2012 mestine 30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Registrar

ERNES TINE

WRIGHT, M.D.

32. Registrar's Signature

MYERS

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aylesworth Murch Marion October 0 2012 5:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Columbia Vantage House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign June 27, 1915 Nebraska Director 506-07-4453 1 D M 2 🔀 F 97 Pege 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 No MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 USA 5400 Vantage Point Road 12. Was Decedent Ever in U.S. Armed Forces? -11. Marital Status 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: Completed 3 X Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Antiques Appraiser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph Sinclair Brown Amy Edith West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard G. Aylesworth/son 3139 Weaver Avenue Baltimore, MD 21214 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1
Department of I
Important: If it
any injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Journey Crematory 10/09/12 Woodbine, MD Signature of Funeral Service License Name and Address of Facility
Name and Address of Facility
Ting Home Cremation Service P.O. Box 784 Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final necmon i'c Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death,

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year ☐ Yes 2 ☐ No 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 🗌 No 1 🗌 Yes Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🗌 Yes Other: 2 **N**O ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in more instances. Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SOR address of erson who completed cause of death (Item 23a) (Type, Print) 6334 Cedar 426.5 (GV4 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

32424

Physici	an	Registrar  1. Decedent's Name (First, Middle, La	st) Naomi C. Mv	ers			te of Death onth Sep 30,ay	2012 Year	3. Time of Death 5:45p	
/Medic	al _	la. Facility Name (If not institution, giv <b>Keswick Mu</b>			City, Town, or Location		•	County of Death		
Funeral				s. last birthday)lf		der 24 Hrs. 8. Da	ite of Birth		iplace (State or Foreig Intry) Md.	
Director		Usual Residence of Decedent  10a. State 10b. County		City, Town or Location	n Balt	imore			10d. Inside City Limit	
a or 28a-f	Directo	10e. Street and Number 2232 West Saratoga Sti	reet	1	Of. Zip Code 21	223	10g. Citi	zen of What Cou U.S.A	of What Country?	
Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f ehow eny injury or other traumatic event. Its Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates:	If Yes	Decedent of Hispanic s, specify Cuban, Mex Yes 2 No Spec	ican, Puerto Rican	es or No- etc.)	14. Race - Amer Black, White Black Specify:	e, etc.	
Hygiene. the than "natural", or iteme 23s or 28s-f ehow ont. Its Medical Examinar must be mollified at	mpleted	15. Decedent's E (Specify only highest gr Elementary/Sepondary (0-12)	ducation a de completed) College (1-4or 5+)	16a. Decedent (Give kind life. DO I	s Usual Occupation f of work done during r NOT use retired) Homemake	most of working	16b. Ki	ond of Business/l		
ed other	Be	17. Father's Name (First, Middle, Las	James Newman	1	18. M	other's Name (Firs	t, Middle, Maiden Edith S. N	Sumame) Newman		
th and Me	Ţ.	19a. Informant's Name/Relationship Naomi J. Myers	(Type, Print)	19h Mailing A 2232 <b>W</b> €	ddress (Street and Nu est Saratoga S	mber or Bural Router treet Baltime	te Number City of Pre, MD 212	r Town, State, Z	lip Code)	
ent of Heal nt: If Item 2 ry or other		20a. Wethod of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State	o. Place of Disposition cometery, cramato Garrison Fore	n (Name of ry or other place) est Veterans	Oct 09, 20		ocation - City or Owings N		
Departm Departm Imports eny inju		21. Signature of Funeral Service Lice	ensee Ester	22. Na	™Estep Brothe fo 1300 Eutaw Pla	≇#tmeral Servace Baltimore	rice, P. A. , <b>M</b> d 21217			
cate be executed by sician and by sician and by sician and by sician and the sician site of the sician sician site of the sician site of the sician sician sician site of the sician sic	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a cons  c.  Due to (or as a cons  d.	sequence of):	1ENTIA				~ Know	
death certifi e ettending od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1	etal death 3 DEc	topic pregnancy ther (specify)			23d. Date of de Month	livery Day Year	
w requires that the been signed by th should be detache	ğ	Part II. Other significant conditions	contributing to death but not	resulting in the unde	rlying cause given in F		1 □ Yes 2	!□No 3□Pi	the cause of death	
the law ete has b page 2 sl	Completed						24a. Was an autopsy performed? 1 ☐ Yes 2 1 N	24b. Were as prior to death?	utopsy findings avail: completion of cause s 2 No	
Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Other	Place of Death (Ch		€ □Othor (Sne	acutu)	
this ald	llon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Yea		28c. Injury at Work?  M 1 Yes	28d.	Describe how inju			
After	flca	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be to Blace of Injury	At home, farm, street ecify)	, factory, office		ocation (Street a City or Town, Sta		lural Route Number,	
or Attending ifter death. Director: After in by the funer	ert		Physician: To the best of my	knowledge, death on the street investigation and/or investigation and the street investigation and the	ccurred at the time, da stigation, in my opinion	ite and place, and on, death occurred a	t the time, date ar	nd place, and du	e to the cause(s)	
or Attending ifter death. Director: After in by the funer	edical Certification:	29a. Certifier 1 Certifying (Check only one)	aminer: On the basis of examiner and manner stated.				1 DA D	ate signed (Mon	th Day Vond	
Hospital or Attending 24 hours efter death. Funeral Director: After tely filled in by the funer	Medical Cert	(Check only 2 Medical Example)  29b. Signature and title of certifier	and manner stated.		29c. License num		101	1/201		
or Attending ifter death. Director: After in by the funer		(Check only 2 Medical Exone)  29b. Signature and title of certifier  30. Name and address of person with the control of the certifier of the c	and manner stated.  Mo	West L	00059	056	101	1,/201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32425 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Month Oct Day Oi 1820M Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Medical Baltimore 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Min (Month, Day, Year) 248-35-1594 **Director** 1 🕅 M 2 🗆 F 52 Oct. 29, 1959 South Carolina Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 900 Shoddard Street 21201 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedon...
Armed Forces?
1 Yes 2 No Black, White, etc by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (Unknown) Lucille McKay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille McNeil (Mother) 2111 Lazy Pines Rd., Darlington, SC 29540 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Round-O Church Cem. 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Darlington, SC 10/6/2012 Donation 5 Other (Specify 21. Sign uneral Service Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 ture of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Magania disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Vear Pregnant at time of death To the Hospital or Atternance within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the an anneletely filled in by the funeral director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of 100554 who completed cause of death (Item 23a) (Type, Brint) the 5100, Baltimore, MD

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 10 Physician/  $P^{M}$ Frances Anne Martin 2012 4:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Potomac Potomac Birthpia. Country) D.C. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 05/12/1918 1 □ M 2 🗗 F **Director** 577-22-2511 94 Yrs Usual Residence of Deceder shov 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28e-f shoury or other treumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 1X Yes 2 ☐ No MDMontgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854-4418 USA 10714 Potomac Tennis Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Engineering 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Percy Klein Esther Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dan Edward Martin / Son 17228 Macduff Avenue, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State permit. Page Department Important: It eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/9/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 1 Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cauce. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use es the burial-transi anding physician and use es the burial-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Vear Pregnant at time of death 5 Other (specify) g 🗌 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' ☐ Yes 2 WN 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I

comple 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054566 October 8, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogavilli, MD. 9801 Georgia Avenue, Silver Spring, MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2012 32427 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 8, 2012 Year Mantheiy Louise 5:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Future Care North Point Dundalk Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Months Hours Director 212-24-0050 1 M 2XXF 85 August 14, 1927 Cumberland, MD. parmit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or items 23e or 28e-f showery Injury or other traumatic event, the Medical Examinar must be multiped at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Dundalk 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2415 Plainfield Road 21222 USA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 X No 1 Never Married 2 Married ۾ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) 12 years 2 vears Instructional Assistant Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Edna Pearl Kyne George Sheetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickie Sobczak Daughter 9912 Marilynn Road, Perry Hall, Maryland 21128 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 1 X Burial 2 Cremation 3 Removal from State Middle River, Maryland 4 Donation 5 Other (Specify) Holly Hill Memorial 11, 2012 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Despetition of enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Hananced Physician/ Demon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physician: Tha law raquiras that within 24 hours aftar death.

To the Funeral Director: Aftar this certificata has baan signed is completaly filled in by tha funeral director, pega 2 should be dat 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours aftar death. 1 Natural 5 Pending Work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of 10-08-2012 M-D-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. EASTERN BLVD, M.D. 21221. 0 MALIKA WASEBM. 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760°

P.O. |

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 32428 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:30 PM Milton Elmer Nebblett Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12118 Mt Albert Road Ellicott City Howard 5. Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 124-26-0732 1X M 2 □ F 88 1/21/1924 Hondoras Usual Residence of Decedent ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location Director 1 ¥ Yes 2 □ No Howard Ellicott City 10e. Street and Number 10g, Citizen of What Country? Funeral 12118 Mt. Albert Road 21042 Hondoras Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married Yes 2 X No ģ Maryland 21215-0036 1 Yes 2 No Specify Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Minister Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lea Douglin permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>Edwin E. Nebblett</u> 19a. Informant's Name/Relationship (Type, Print) 12118 Mt. Albert Rd. Ellicott City, Ivy Nebblett/Wife Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 9/30/2012 Laurel, MD cemetery 21. Signature of Funeral Vice cer see 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE, Wash, DC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Atherosclerolic Cardiovascular Disease disease or condition Medical resulting in death) Examiner Advanced Dementia Sequentially list conditions, cause. Enter Underlying Exam Deep Venous Thrombosis Lower Extremity burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending place as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Yes 2 No ed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has tetely filled in by the funeral director, page 2 setely filled in by the funeral director, page 2 setely filled in by the funeral director, page 2 setely filled in by the funeral director, page 2 setely filled in by the funeral director, page 2 setely filled in by the funeral director. autonsy performed? Yes 2 N Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours aft

To the Funeral Discompletely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

(Check

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

E Clanul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapalm

DHMH 17 Rev 06-2011

201-109

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1) 30641

29d. Date signed (Month, Dav. Year)

Back River Neck Road Balhom Mayluk

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Antoinette Theresa Nelson 2012 6:00 P M Pctober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cherrywood Nursing Home Reisterstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Min. (Month, Day, Year) 69 Director 219-40-4232 1 □ M 2XXF April 24 1943 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director 1 Yes XXNo Baltimore Owings Mills MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21117 II.S.A. 35 Wengate Rd. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes X N No
If Yes, Give Black, White, etc. þ 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours a Department of Health end Mental Hygiene. Important: If item 27 is marked other then "natural" eny injury or other traumatic event, the Medical Exagonose. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Dominic DiStefano Carmella Leana Manno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Wengate Rd. Owings Mills, MD 21117 Craig S. Nelson / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemejery, crematory or other place)
Garrison Forest
Veterans Cemetery 10/12/12 1XXBurial 2 Cremation 3 Removal from State Owings Mills, MD 4 Donation 5 Other (Specify) Signature of Fundal Sovice Licensee 22. Name and Address of FacilitEckhardt Funeral Chapel, P.A. Callen 11605 Reisterstown Rd. Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Vetadatic adend Ca - unknown Physician disease or condition resulting in death) 400 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, eaching to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of: the Hospital or Attending Physicien: The lew requires that the death certificate be executed in 24 hours after death.

The funeral Director: After this certificate has been signed by the attending physician and repletely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2-No
9 Unknown 4 Pregnant a Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 ☐ Yes 2 → No Other: Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2
To the F 29b. Signature and title of certifier 037573 9, 2012 30. Name and address of person who complete of death (Item 23a) (Type, Print) MD MD PO Salisbu 2613

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

10

2012

32. Registrar's Signatu

12-07509 Randy Owens Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		- For State	Certificate	of Death	Reg	J. No.	
Physician		l. Decedent's Name (First, Middle,Last)			Date of Death     Month	Day Year	3. Time of Death
Medical Examin		RANDY OUSE	11.5		October 3,	2012	2132 hrs
		4a. Facility Name (if not institution, give stre	et and number)	4b. City, Town, or Location of De	ath	4c. County of Deat	h
		University Hospital		Baltimore		1	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	/) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Bi	rthplace (State or
Director			n 10	Yrs. Months Days Hours	Min. of / 1.	// Forei	gn ountry) // /
Directo.	L	2/4 1/2001 =	2 F /9	115.	F/W/	1799	1/10
<b>b</b>		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
w any		Tod. State		/			1 Yes 2 L No
and sho	5	MD Baltine	ore Dal	THURE			
Maryland 28a-f show	ᅜ	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	untry?
the N	Director	743 Howard	Roax	21208		USA.	
with th		11. Marital Status 12.		. Was Decedent of Hispanic Origin?	( Specify Yes or No-		rican Indian, Black,
item	Funeral	1 Never Married 2 Married	Armed Forces?	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	White, etc.	, ,
, or		3 Widowed 4 Divorced If Ye	s, Give Year	Yes 2 No specify:		Specify: 4	Kite
irs af	좕	15. Decedent's Education (Specify only his	hest grade completed) 16a. Dec	edent's Usual Occupation (Give kind	of work done	16b. Kind of Business	/Industry
2 hou	홟	Elementary/Secondary (0-12)	College (1-4 or 5+)	ng most of working life. DO NOT use	retired)	2	,
36 Jin 7	픫	8	Ax	renter (ADX	riteR	CONSTRIA	e HON
With Sprence	Completed	17. Father's Name (First, Middle, Last)	1///	18. Mother's N	ame (First, Middle, M	aiden Surname)	
filed THy	Be	Taylo.	10	Phon	NA R	in tech 1	/
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than cevent, the Medical	8	19a Informant's Name/Relationship (Type	/ S 19b. N	ailing Address (Street and Number	or Rural Route Numl	ber, City or Town, at	e, Zip Code)
shou and h	၉	VI Maria Ball	Firmore County 6.	401 Wood Ra	ad Shall	thance.	M / 2/2/2/
MD and 2 sho alth and sm 27 is	- }-	TEVE HCERNO - FO 20a. Method of Disposition	20b. Place of D	isposition (Name of cemetery,	Date	20c. Location - City of	r Town, State
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.			emoval from State crematory	or other place)	/ /	1.1	(1)
Page lent c	- 1	4 Donation 5 Other Specify:	Dayvio	W Crenatury	0/8/12	na/tinu	Re / MA
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other ti injury or other traumatic event, the Med	ı	21. Signature of Funeral Service Licensee	7	22. Name and Address of Famility	radley -	ASKTON.	Fungeral
<b>0</b>	1	alalak		Home, PA, 213	410/110	W. SDrIN	C Rd. 21222
Physician	寸	23a. Part I. Enter the disease, or complicati	ons that caused the death. Do not e	nter the mode of dying, such as cardi	ac or respiratory arre	st, shock, or heart —	Approximate Interval Between Onset and
/Medical	- 1	failure. List only one cause on each li	tiple Gunshot Wounds				Death
Examiner	- 1		to (or as a consequence of):				
	- 1	Sequentially list conditions, b					
	힐	if any, leading to immediate Due	to (or as a consequence of):				
	뉡	(Disease or injury that initiated					1
sit d	Examiner	events resulting in death) Last Due	to (or as a consequence of):				
760, icate be executed physician and the burial - transit		d	4511050				
be ex	Medical	UNPENDED	MENDED			1	
760, icate be gather the buria		IF FEMALE: 2 23b. Was decedent pregnant in the	Bc. If yes, outcome of pregnancy	Tectoric pr	ananay	23d. Date of delive Month	Day Year
687 certifi	E	past 12 months?	Pregnant at time of death 5	Fetal death 3 Ectopic pr	sgilaricy	liviona.	50,
Box 68 e death certifuther attending ed for use as	Sic	1 Yes 2 No 9 Unknown		Other (Specify)			
he de y the	Physician	Part II. Other significant conditions con		the underlying cause given in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
that t	à	Part in Other Significant Conditions	and and a decirious and a deci		1 Yes	2 No 3 Pr	obably 4 🗹 Unknown
uires n sign					24a. Was a	an 24b Were	autopsy findings available
v req	흥				autop:	sy prior to	completion of cause of
ecc he la tre ha	Completed				1 Yes		
ii Ti	Ö	25. Was case referred to medical		26.Place of Death (Ch	eck only one)		
is cer	<b>1</b>	examiner? 1 ✓ Yes 2 No	ital: 1 Inpatient 2 🗸 ER/Outp	atient 3 DOA Other N	ursing Home 5	Residence 6 Oth	er:
Phy eral of	٤	27. Manner of Death		ne of Injury 28c. Injury at Work?		now injury occurred	
ding	悥	1 Natural 5 Pending	Oct 3, 2012 2104 h	rs 1 Yes 2 ✔ No	Subject sho		
SiO Affe cetor by th	g	2 Accident Investigation	2Be. Place of Injury - At home, farm	street, factory, office building, etc.	28f. Location (S	Street and Number or I	Rural Route Number, City
Jivis I or A after I Dire	Certification:	3 Suicide 6 Could not be determined	(Specify) Local Street	,	or Town, S 200 North Full	tate) ton Avenue, Baltime	ore, MD
Division of Vital Records, P.O. Box 687 To the Hospital or Atteoding Physician: The law requires that the death certifit within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	S	4 V Homicide		occurred at the time, date and place			
n 24 n 24 n 24 n 1 e Fu	ca	(Check only 1 Certifying Physician:	the basis of examination and/or inve	estigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
Di To the Hospital within 24 hours a To the Fuoeral I completely filled	Medical	and	manner stated.	29c, License number		29d. Date signed (A	
	Σ	29b. Signature and title of certifier	4/			October 4, 201	
20		Theodor M-	Ring JR. M.	O.C.M.E.		JC(000) 4, 201	~
0		30. Name and address of person who com	oleted 0 e of death (1 m 23a)			0.4000	
		Theodore M. King, Jr., MD.	Assistant Medical Examin	er 900 W. Baltimore Stree	t, Baltimore, MI	J 21223	
St	ate	31. Date filed (Month, Day, Year)	32. Registrats Signature	1			
Regist		OCT 1 0 2012 /2-	was a. alarka				

Pakinh Known as Rosita ORT12

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  amend #14 Per FH g932 10/10/2012 JH State of Maryland / Department of Health and Mental Hygiene 2012 3243										
	-	1 - State of Maryland / Department of Health and Certificate of Death								
Physicia	an/	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	3. Time of Death						
Medi Exami	_		1	2012 05:35 PM 4c. County of Death						
Filmount		Sinai Hospital of Balkmore Balkmore City 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	<u> </u>	9. Birthplace (State or Foreign						
Funeral Director		217-90-3764 1 M 2 XF 45 Yrs. Months Days Hours Mi		965 Maryland						
/land f show dat	ig	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location		10d. Inside City Limits						
he Mary or 28a-	Direc	Maryland V/A Baffins Ve 10f. Zip Code	10g.	1 b Yes 2 No Citizen of What Country?						
h with t ns 23a must be	Funeral Director	The 1012 Forrest VIEW Rd Apt B 2/206	B	ack USA						
15-0036 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	by Fu	1 Never Married 2 Married 1 Types 2 No	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.						
215-0036 in 72 hours after e. nan "natural", o Medical Exam	eted	3 Wildowed 4 Divorced If Yes, Give Year or Dates.  15. Decedent's Education 16a, Decedent's Usual Occupation	16b	Specify: Slack  Kind of Business Industry						
21215 within 72 l giene. er than "n ; the Medi	Completed	(Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  (Give kind of work done during most of which is possible in the possi	vorking	ast Food						
nd 21 filed with al Hygien d other the	Be	17. Father's Name (First, Middle, Last) , 18. Mother's N	Name (First, Middle, Maide	en Surname)						
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	안	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or a	1 1110	or Town, State, Zip Code)						
Mand 2 sh Health ar Her trau		Tia Arthur - Daughter S300 Midwood	Ave Bal	to, MD 2/2/2						
or it see		20a. Method of Disposition  1		Batto, MD						
Baltim permit. Pag Department Important: any injury o		21. Signature of Funetal Service Licensee  22. Name and Address of Facility  Address of Facility	- LAMS F	Sto: mo 2/229						
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	iac or respiratory arrest,	Approximate Interval Between						
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)  Sepsis  Due for as a consequence of:		Onset and Death 2 days						
Examiner		Bacteremia		2 days						
ted d insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or unjury		2 days						
oe executed cian and ourial-transit	1= 1			0						
68760 certificate be nding physici use as the bu	Medic	d								
Box 6 death cert he attendir	cian/I	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)		23d. Date of delivery Month Day Year						
P.O. B that the de ned by the e detached	Physi	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	22a Did tabasa	o use contribute to the cause of death?						
	Completed by Physician/Medica	Diabeto mellitus type 2, COPD,		2 No 3 Probably 4 Unknown						
Division of Vital Records, tal or Attending Physician: The law requires rs after cleath.  al Director: After this certificate has been signed in by the funeral director, page 2 should b	nplet	Pulmonary embolism, Right heart fally	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?						
	Be Cor		1 \( \text{Yes} 2 \( \text{X} \)							
ision of Vital Attending Physician: or death. ector: After this certific by the funeral director,	년 원 일 8	examiner? 1 Yes 2 No 1 Nursing  Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing  27. Manner of Death  28a. Date of injury  28b. Time of  28c. Injury at	g Home 5 Residence							
OD O ending eath. or: After he fune	Certificate: To	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation 3 Suicide 6 Could not be	Zad. Describe flow in	jury occurred						
ivisi or Atte after de Directo	Certi	3 ☐ Sulcide 4 ☐ Homicide  3 ☐ Sulcide 4 ☐ Homicide  5 ☐ Could not be determined	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)						
Division of Vital To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Medical	29a. Certifier (Check 1 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred the time.	ed at the time, date and pla	ace, and due to the cause(s) and manner stated.						
To the within 2 To the comple	ž	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)						
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	) Oc	hober 02, 2012						
21		NAMITA SINGH, MBBS Sinai Hospit	al of Bo	Minore						
Sta Regist		te 31. Date filed (Month, Day, Year) 32. Registrar's Synature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 22, 2012 William Person 2144 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Capitol Heights 1305 Early Oaks Lane 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) **Director** 238-72-6968 1 🕅 M 2 🗆 F 66 November 27, 1945 NC "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Prince George's Forestville 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's Funeral 7173 Donnell Place 20747 U.S. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Person, Sr. Esther Mae Silver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 Early Oaks Lane, Capitol Heights, MD 20743 Tiffanie T. Montague/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place remation Center of Maryland October 9,2012 Hanover, MD 22 Mame and Address of Facility Certar Hill Funeral Home, Inc. 21 St nature of Fundral S 4111 Pennsylvania Avenue, Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused shock, or heaft failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Control the Hospital or Attending Physician: The law requires that the death certificate be executed. that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

Yes 2XX No Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2**XX** No 1 Tyes Other: Certificate: To 4 Nursing Home 5 Residence W Other (Specify) Daughter's 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Residence 1 XX Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29c. License number 29d. Date signed (Month, Day, D25001 September 26, 2012 O. Name and didress of person in completed cause of death (Item 23a) (Type, Print) Jay Lippman, 1801 McCormick Drive, Largo, MD 20774

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

1 0 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	tate of Maryland		irtment of H tificate of D			ene 20	12	32433				
	Physicia		Decedent's Name (First, Middle, Last)  WILLIAM S. PRICE					2. Date of Death Month	Day Ye	ear	3. Time of Death 4:00AM M				
 ز	Medic Examin		4a. Facility Name (if not institution, give street 6015 Point Pleasant			4b. City, Town, or Baltimor	4c. County of								
	Funeral Director		5. Social Security Number 6. Sex 214~36~9371 1 🔀 M	7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   Months   Days   Hours   Min. (Month, Day, Year)						Birthplace (State or Foreign Country)					
	10000	٦٢	Usual Residence of Decedent  10a. State 10b. County		Yrs. Town or Loc	ation		Aug. 13,	1939	MD.	od. Inside City Limits				
	Maryla 28a-f s otified	irecto	Maryland Baltimore			_	imore Cou	unty			1 ☐ Yes 2 <b>X</b> XNo				
	s 23a or	Funeral Director	10e. Street and Number 6015 Point Pleasant	Rd.		10f. Zip Code	21206	10	10g. Citizen of What Country? USA						
9600	urs after death tural", or item al Examiner m	by	1 Never Married 2 Married	Vas Decedent Ever in U.S. Armed Forces? ☐ Yes ②XX No f Yes, Give /ear or Dates.		/as Decedent of His Yes, specify Cubar		ecify Yes or No- Rican, etc.)	14. Race - Black, \ Specify:	Vhite, et	tc.				
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "natu the Medica	Be Completed		on mpleted) College (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done do NOT use retired) amfitter	ation uring most of worki			Gind of Business/Industry al 486 Plumbers & amfitters Union					
and	ntal Hyg ed othe: event,	To Be	17. Father's Name (First, Middle, Last)  Joseph Tomalonis	· · · · · · · · · · · · · · · · · · ·				e (First, Middle, Ma Gladys St	,						
aryli	hould to and Me s mark numatic		19a. Informant's Name/Relationship (Type, P	ity or Town, State	State, Zip Code)										
e, Z	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Rodney Price (Son)  20a. Method of Disposition	agi. Bi-		Point Pl									
imor			1   ■ Burial 2 □ Cremation 3 □ Remarks 4 □ Donation 5 □ Other (Specify)		n - City or Town, State										
Balt	permit. Departi Import any inj		4 Donation 5 Other (Specify) Parkwood Cemetery 10-8-2012 Baltimore, Mo 21. Signature Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236												
aribes (	Phylician Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ear 1 line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):													
المري	Examiner	L	Sequentially list conditions, b. —	Due to (or as a conseque	nce of):										
	rted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
_	cate be executed physician and s the burial-transit	edical Ex	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):										
8760			IF FEMALE:						1						
R-cords, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certification of the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	by Physician/N	23b. Was decedent pregnant in the past 12 months?	f yes, outcome of pregnand Live Birth 2 Fetal of Fregnant at time of dea Fregnant at time of dea	death 3 🗌	Ectopic pregnancy Other (specify)	ý		23d. Date o Month		ry Day Year				
ds, P.0	equires that the sensigned bould be deta	ted by P	Part II. Other significant conditions contribu	ating to death but not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did toba 1 □ Yes	$\sim$		e cause of death?				
R CO	The law restarte has be	Completed						24a. Was an autopsy performe	prio	r to com	sy findings available inpletion of cause of				
/ital	sician: certific director,	To Be	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \sum \) No	tal: 1 ☐ Inpatient 2 ☐ El	P/Outpotion	Other	r:	me 5 Residen	C						
Division of Vital	ending Phy sath. or: After this he funeral o	Certificate: T	27. Manner of Death   Natural 5  Pending 2  Accident Investigation		8b. Time of injury	28c. Injury work?	at	28d. Describe how		респу)					
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Ru City or Town, State)											?oute Number,				
_	ne Hospittiin 24 hours ne Funera pletely fille	Medical	(Check Medical Examiner: C	To the best of my knowled on the basis of examination a ctitionar: To the best of my	and/or investi	gation, in my opinior	n, death occurred at	the time, date and	place, and due to	the caus	se(s) and manner stated.				
	To the within com		29b. Signature and title of certifier	Micho 5	25	29c. License	number 3681U	290	d. Date signed (N	onth Da	ay, Year)				
	SM		30. Name and address of person who comple	eted cause of death from 2	3a) (Type, Pi	int) or KR	and L	udheri	orler	NID	2193				
	Stat Registra		31. Date filed (Month, Day, Year)  OCT 1 0 2012	32. Registrar's Signatur	back	,									

SITIAM S. TRIGH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ PAULINE ELIZABETH PURKINS 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) 215-09-2554 Director 1 □ M 2 🛣 F 94 MAY 18, 1918 MARYLAND Usual Residence of Decedent 27 is marked other then "neture!", or items 23e or 28e-f show treumatic event, t<u>re Modioal Examiner must be notified at</u> 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State Director MAYRLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 UNITED STATES 413 DELMAR AVE. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc., PAULIN 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) end Mental Hygiene. is marked other then Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be Ped 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MATILDA OTTO end 2 should be JOHN QUERFURTH PURKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 860 BRIGHTON PL., GLEN BURNIE, MARYLAND 21061 f Heelth ALFRED F. PURKINS / SON permit. Pege 1 end 2 Depertment of Heelth Important: If Item 27 eny Injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) OCT. Date 20c. Location - City or Town, State 1 🖾 Byrial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2012 GLEN BURNIE, MARYLAND GLEN HAVEN MEM. PK. RIRRIEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 f Funeral Service Lig 21. Signatu 9 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Priysician neumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physicien: The lew requires thet the death certificete be executed within 24 hours efter death.

To the Funerei Director: After this certificete has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Cause (Disease or Injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DO073466 MD October 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital drive Glen Burnie

4:05 AM

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

1 Yes 2 XNo

State Registrar

301

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SON If Under 24 Hrs. OU If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Director 1 M 2 W 40 or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, and the fire 23s or 28a-f show ant: If Hem 27 is marked outher than "natural", or Items 23s or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No da 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced 4 Divorced Specify: NKIFE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of College (1-4 or 5+) Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date per nt. Page 1
Der artment of
Important: If it
any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility white 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
within 24 hours after death.
The Funeral Director After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, Completed 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 6 Could not be 1 Tes 2 🗌 No Suîcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Undedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. nly one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title who completed cause of death (Item 23a) (Type, Print) (onth, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Oct. 12:34pM David Bruce Rambol Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Aug 1937 communication of the communica 75 Director 213-34-9637 1 M 2 □ F 27 is marked other than "natural", or items 23a or 28a-f shov treumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Penn. York Hanover 1 🗆 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23 Ivy Circle 17331 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Mamed 2 Married ģ ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes. Give Specify: White 3√XWidowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Should be filed within 72 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Systems Analyst Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Francis Rambol Bertha Molnaur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2305 Mt. Ventus Rd.#1, Manchester, M permit. Page 1 and 2 sh Department of Heatth ar Importent: If item 27 is eny Injury or other treu Susan Geiman - daughter МD. 21102 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Oaklawn Cem. Oct: 11,2012 Baltimore, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel . Harth Telleto B296 Charmil Dr. Manchester, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition 1000 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Other: 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural Accident 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2115

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

enda Rickard		1- For State Registrar	e of Maryland / Depa <i>Cer</i> i	rtment of <i>tificate of</i>		Mental Hy	rgiene Reg.	No.	
Physici ledical Exam		Decedent's Name (First, Middle,L.	SSt)	<del></del>			2. Date of Death  Month  October 6, 2		3. Time of Death
Tedical Exam	11161	4a. Facility Name (if not institution, g			lb. City, Town, or Lo	ocation of Death	October 6, 2	4c. County of Deat	
		610 North Chapel Gate I		h: at- 1 \	Baltimore		To be a Court	MA	att along (Ölata
Funeral Director		094-42-399/ 1	Sex 7. Age (In yrs. la	Yrs.	If Under 1 Year  Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth (I	Foreig	thplace (State or gn puntry)
any		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Locati	on		_		10d. Inside City Limits
Maryland 28a-f show any d at once.	힏	MB N	/A 9	PALTIM	1015				1 Yes 2 No
th the Maryland 23a or 28a-f she notified at once	Director	10e. Street and Number	MASON I CONTE LO	11/1-	10f. Zip Code	a	10g.	Citizen of What Cou	ntry?
h with 1 ms 23s	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		s Decedent of Hispa es, specify Cuban, I			14. Race - Amer White, etc.	ican Indian, Black,
er deat , or ite		1 Never Married 2 Marrie 3 Widowed 4 Divorce	1 Yes 2 No		Yes 2 No		tiodii, cioi,	Specify: 43/	ar V
ours aft atural' xamine	d by	15. Decedent's Education (Specify	or Dates:	16a. Decedent	t's Usual Occupatio	n (Give kind of w		6b. Kind of Business/	Industry
036 ithin 72 hou ene. rr than "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		CCOUNTAL	O NOT use retir	ed)	BGE	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be	17. Father's Name (First, Middle, La:	5N9			Juan	(First, Middle, Main	TORS	
nore, MD 21 ages 1 and 2 should nt of Health and Mes 1: If item 27 is man other traumatic ev	5	19a. Informant's Name/Relationship	KART	19b. Mailing	2 MRT	19/1/22	TRIVE Y	r, City or Town, State	21230
nore, ages I an nt of Hea nt: If iter	ľ		Removal from State	Place of Disposi rematory or oth	ition (Name of ceme	tery, 10-1	Date 2	Oc. Location - City or	Town, State
Baltimore, permit. Pages 1 ar Department of He Important: If ite		21. Sign of re of Funeral Service Lice		22. N	ame and Address o	f Facility	O PANN	1500	2.2.29
Physician		23 and Enter the disease, or configuration one cause on		Do not enter th	mode of dying, su	ich as cardiac or	respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Total Control of the	a. Complications of quadri						Death
M			Due to (or as a consequence of b. Motor Vehicle Accident	);,					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	):					
ed	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	):					
0, e be executed sician and burial - transit	edical I	UNPENDED	dAMENDED						
760, icate be expression the burial	/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn	nancy				23d. Date of deliver	y
Box 68761 death certificate he attending phy d for use as the b	Physician/M	past 12 months?  1 Yes 2 V No 9 Unknow	1 Live birth 4 Pregnant at time of death 9 Unknown		al death 3 ner (Specify)	Ectopic pregnar	ncy	Month	Day Year
P.O. Es that the d		Part II. Other significant conditions		sulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
S, P.C uires that n signed Id be deta	ed b							2 V No 3 Pro	pably 4 Unknown
Records, The law require ficate has been si, page 2 should b	Completed by						24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
tal Rec tian: The l certificate bector, page		OF Was and referred to madical					1 Yes 2		es 2 No
Vital hysician this cert	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient		Death (Check o		sidence 6 🗸 Othe	r: Scene
1 Of ling Pl After funera	tion: To	27. Manner of Death  1 Natural 5 Pending	Mar 23, 1989	28b. Time of Ir 0000 hrs			28d. Describe how Motor vehicle a	injury occurred	
or Atta	tifica	2 Accident Investiga 3 Suicide 6 Could no	ot be 28e. Place of Injury - At hor	me, farm, stree	t, factory, office buil	ding, etc.	28f. Location (Stre or Town, State		ral Route Number, City
ospital ospital hours uneral ly fillec	Se	4 Homicide determine 29a. Certifier	(Specify Townhouse				orest Park Ave	& Security Blvd, B	
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	one) 2 Medical Examin	cian: To the best of my knowledger: On the basis of examination an and manner stated.				the time, date and	l place, and due to th	e cause(s)
<b>,</b>	Ž	29b. Signature and title of certifier	M. 1/		29c. License r			9d. Date signed <i>(Mo</i> October 9, 2012	nth, Day, Year)
5V		30. Name and address of person who Jack Titus MD. Deputy	completed cause of death (Item) Chief Medical Examiner	- 1	altimore Stree	t, Baltimore,	MD 21223	·	
Si Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Sar	w				
				10	-		_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year :46 <u>Gera</u>ld Τ. Richardson Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death County of Death ton 9. Birthplace (State or Foreign **Funeral** Age (In yrs. 8. Date of Birth (Month, Day, Year) **Director** 1 **X** M 2  $\square$  F July 28,1944 Washington D.C. 68 Usual Residence of Dece or 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Anne Arundel Pasadena Maryland 9 10f. Zip Code ral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral 7610 Beach Drive 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give by 1 Never Married 2 Married Black White etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates White r than "nature the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Superior Court of Elementary/Secondary (0-12) College (1-4 or 5+) alth and Mental Hygiene. other traumatic event, the Commissioner Los Angeles California Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Ments Francis Χ. Richardson Helen Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7610 Beach Drive Pasadena, Maryland 21122 Karen M. Richardson (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/09/2012 Glen Burnie, Maryland Atlantic Cremation Signature of Emeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 MOO-732 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (ur de a conesquence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month 1 | Yes 2 | 9 | Unknown Part II. Other significant cenditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: မ 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D32744 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / D **Physician** 2012 9.50AM /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore OVERIEA HEAlth Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 😿 F 218-28-4278 **Director** 03-22-Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at MD Director 1 Yes 2 □ No BAUTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5634 BELAIR 21206 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 □Yes 2 No Specify δ 3 ₩ Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, The M College (1-4or 5+) PRIVATE 12 ARETAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KUSSELL George ပ LILLIAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LEXINGTON PARK. MD. 20653 HOLMES MICHAEL 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗗 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-11-12 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNGARISEVS 21. Signature of Funeral Service Licensee 4905 YUK ROAD . BATIMORE, MD. 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) //Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Was an has autopsy Physician: The certificate 1 Tyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Member of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation death. filled in by the 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

of Vital Records, Division Hospital or Attending within 24 hours after deatl To the Funeral Director: completely

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

State Registrar

29a. Certifier

(Check only one)

30. Name and address

31. Date filed (Month, Day,

29b. Signature and

completed cause of death (Item 23a), (Type, Print) Laven Blue

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 7:47 P M TROY ANDREW STULEN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA Social Security Number 8. Date of Birth May 23, Year 992 7. Age (In yrs, last birthdav) If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 14 M 2 □ F 9. Birthplace (State or Foreign Days Hours Min. Months Minnesota Director 472-25-1929 20 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nortified to once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MN Kandiyohi Willmar 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1412 17th Street SW 56201 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Student Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Larry Stulen Marilyn Tensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 17th St. SW Willmar, MN 56201 Larry Stulen (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Willmar, MN 4 Donation 5 Other (Specify) Fairview Cemetery 9/15/2012 21. Signatury of Funeral Service Ucenşee 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, VA 22310 Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final stemic Physician/ disease or condition weeks Medical resulting in death) (or as a consequence of): Examiner months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Yes 2 After this certificate 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural in 24 hours area control and Funeral Director. Aft 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Division of Vital Records, P.O. Box 68760 To the F

> State Registrar

29b. Signature and title of certifie

HARRY L. MALECH

HARRY L. MALEUH, MD

31. Date filed (Month, Day, Year) ß2. Registrar's Signature OCT 1 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0033308

29d. Date signed (Month, Day, Year)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

12012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25, per me, g932 10-23-12 sm
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gwendolyn Claudette Page Strong Physician/ Month Day Year 07 Medical october 2127PM 2012 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Agnes 5+ Hospital WD Baltmore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 215-34-7631 (Month, Day, Year) Days Hours Min. **Director** 1 M 2 WF Yrs. North Carolina March 22, 1935 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Mary land 1 ☑ Yes 2 ☐ No 10e. Street and Number Avenue, Apartment 707 10f. Zip Code 10g. Citizen of What Country? 700 Pennsylvania Funeral 21201 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Newer Married 2 Married ☐ Yes 2 🖸 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", If Yes, Give Specify: Black 3 ₩Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ifiled within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Drugstore Manager æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Theo G. Page Catherine Joyner ge 1 and 2 should by it of Health and Mer If itam 27 is marke 19a. Informant's Name/Relationship (Type, Print) Cynthia E. Muhammad - Daughter 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 1019 Marksworth Road, Catonsville, MD. 21228 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ita
any injury or oth 20b. Place of Disposition (Name of Oct. Date 15 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) OWNIGS Mills, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Parker Funeral Home, P.A. 3512 Frederick Avenue, Baltimore, MD. 2/229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sephic SHOCK disease or condition resulting in death) da Medical Due to (or as a consequence of): Examiner Pheumonia 1-2 days Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Changrene
Due to (or as a consequence of): with wound ween physician and s the burial-trans that initiated events resulting in death) Last TON APPROVED BY MEDICAL EXAMINER Physician/Medical Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vaccidar 1 Yes 2 No 3 Probably 4 X Unknown tibrill ahan 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Rheumatoid Hospital or Attending Physician: The 1 Yes 2 No 1 Yes 2 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ·WD P25498 october of 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Bahmore, MD, 21229 Nath Pant, 900  $\leq$ . caton 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

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السر	Examir	ıer	4a. Facility Name (if not institution University of Ma			Ctr.		Location of Death	1	4c. Cour	nty of Death			
	Funeral Director		5. Social Security Number	6. Sex 1 XM 2 □ F		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D		9. Birthp Count	place (State or Foreign try)		
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Baltimore,	permit, Page 1 and 2 Department of Health Important: If item 23 any injury or other t		20a. Method of Disposition 1 □ Burial 2 🏅 Cremation	,	20b.	Place of Dispo		!	Date	T	n - City or To			
<u>ti</u>	nit. Pag artment ortant: injury c		4 ☐ Donation 5 ☐ Other (S	Specify)	Me		ematory,							
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1	Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):	erclosal E	sheed . 1	water.					
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 ☐ Fe gnant at time o	etal death 3 🗌	Ectopic pregnanc Other (specify)	у			Date of delive Month	ery Day Year		
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tal F	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		anders state the	*	ace of Death (Chec	l 1 ∐ Yes ck only one)	2 No	T □ Yes	2 L NO		
of Vi	g Physi er this c eral dir	e: 1	1 Yes 2 ☐ No 27. Manner of Death	28a. Date	of injury	ER/Outpatien 28b. Time of	t 3 DOA Othe	4 ☐ Nursing H		how injury occu				
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	SIN		30. Name and address of person of AMMAR A L-HAS	SHUL	se of death (Ite	m 23a) (Type, P	rint) Greene	Street,	Ballen	ove, M	) 21	201		
	Stat Registra		31. Date filed (Month, Đey, •Year)	0 2012	legistrar's Sign	ature								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 2012 Paul Edward Turner 10:05 P™ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours 375-26-1316 Director 1 😾 M 2 🗆 F 12/15/1929 MI 82 Usual Residence of Decedent artment of Health and Mental Hygiene. octant if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 Tes 2 No Anne Arundel Annapolis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7101 Bayfront Dr. Apt. 306 21403 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☑ Yes 2 ☐ No 1947 If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 🗓 Widowed 4 🗆 Divorced 1948 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Public Affairs Executive Nuclear Power Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Marcus Turner Vernice Snay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perinit. Page 1 and 2 sh Derartment of Health an Important: If item 27 is any injury or other trau Paul Turner / Son 1762 Terrace Dr., Belmont, CA 94002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/9/2012 Edgewater, MD 4 Dopation 5 Other (Specify) Kalas Crematory 21. Signature of Functal Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Munay Sequentially list conditions. if any, leading to immedia cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical å 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural Accident 4 hours after death. uneral Director: After ely filled in by the fun 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Mointh, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 32. Registrar's Sig State OCT 1 0 2012 Registrar

DHMH 17 Rev 06-2011

Box 68760

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AMEND ITEM#20b.c.perFH, g932, 10/10/2012, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 9:40p M Toshio Thompson Medical Oct 4, 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A **Baltimore** Joseph Richey Hospice, Inc. If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Hours Min. Country) Director 1 **K** M 2  $\square$  F Japan 577-68-3364 62 Yrs Mar 25, 1950 r then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No **Baltimore Baltimore City** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21230 2363 Annapolis Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. à 1 Never Married 2 D Married 1 Ves 2 No 11/21/196 If Yes, Give Maryland 21215-0036 within 72 hours efter 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 6/5/1971 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 end 2 should be filed within 72 l. Department of Health and Mentel Hygiene. Importent: If item 27 is merked other then "na any injury or other treumatic event and once." 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore City** Trash Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **Grand C Thompson** Akiko Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21230 2363 Annapolis Road, Constance Green Thompson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Zion Crownsville Veterans Cemetery Lansdowne Grownsville, Md. Oct 16, 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore. Md 21217 23a. Part 1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart kilure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) rr hog Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Pregnant at time of death is certificate hes been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate hes autopsy death? 2 No 1 🗌 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 K No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or Division of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and Ittle of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 1290 16-51/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEUTAN ST#305BALTIMOREMS 821 KRi SHN 0 Tre 31. Date filed (Month, Day, Year) State Registrar

MOOK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1232 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Bon Sewars Baltimore Health If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) May 13, 1945 1 M 2 F 212-44-5549 67 MD Director Usual Residence of Decede ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore** MD **Baltimore City** 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 21229 U.S.A. 816 Wicklow Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in LLS. 14. Race - American Indian Armed Forces? 1 Yes 2 No 5/27/1966 Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Black Yes Give 5/24/1968 Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Janitor C & P Telephone Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o **Gladys Thomas David Thomas** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is 816 Wicklow Road Baltimore, MD 21229 **Eugene Thomas** Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Page 1 a 5 Oct 17, 2012 Important: It any injury or Owings Mills, Md. **Garrison Forest Veterans** 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility
 Estep Brothers Funeral Service, P. A.
 1300 Eutaw Place Baltimore, Md 21217
 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Н Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to or as a conse wence of cause. Enter Underlying Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform Hospital or Attending Physician: The 24 hours after death.
Funeral Director, After this certificate I 2 🗌 No filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 🗆 Yes 2 No Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 ☑ Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) DOO 71837 10,05,2012

DHMH 17 Rev 06-2011

State Registrar 200 W. Baltimore St. Baltimore MD 21223

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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12-07489

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lary E. Taylor	- 1	State of Maryland / Department of Health and Mental Hygiene  1-For State RegIstrar  Certificate of Death Reg. No. 2012 324	4
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year	
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
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21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (First, Middle, Last)  Thomas E. Reid  Alice Lam	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once	P	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Josephine Blondell (Daughter)   106 Juniper Ct., Glenburnie, MD 21060	
Baltimore, MD 2 permit. Pages i and 2 shoul Department of Health and M Important: If item 27 is mijury or other traumatic	ŀ	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date  20c. Location - City or Town, State crematory or other place)	
timo L. Pages tment of rtant: 1		4 Donation 5 Other Specify Maury Cemetery 10/8/2012 Richmond, VA	_
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Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  At heavy least in Cardia resources Disease a complicated by Head Injuries.	
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease complicated by Head Injuries  Due to (or as a consequence of):	
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ion of Vital Records, P.O. Box 6876( ttending Physician: The law requires that the death certificate  teath. stor: After this certificate has been signed by the attending phy,  the funeral director, page 2 should be detached for use as the b.		27. Manner of Death  1 Natural 5 Pending 28a. Date of Injury	
Division of Vital Records, ral or Attending Physician: The law requir rs after death.  al Director: After this certificate has been s led in by the funeral director, page 2 should the fine of the funeral director, page 2 should the funeral director.	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc.  3 Suicide 6 Could not be determined determined (Specific) Nursing Home.	ity
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To the within To the complete	Medical	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
		O.C.M.E. October 3, 2012	
6		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
4	ate		
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ono	Attending Physician: or death. ector: After this certific by the funeral director.	icat	1 ☑ Natural 2 ☐ Accident	5 Pendin	ation (Mo	nth, Day, Yea		ury M	work			ou. Describe	now inju	iry occurre	u		
To to the first of										8f. Location (			r or Rura	Route Number,	Т		
Ω	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1	Certifyina	Physician: To the	best of my k	nowledge, d	eath occurre	ed at the time	e, date and	place. an	d due to the	ause(s)	and mann	er as stat	ed.	_\
	he Ho in 24 t he Fur	Medical	(Check 2 only one) 3	Medical E	caminer: On the banks	asis of examin	ation and/or	investigation	, in my opinio	on, death oc	ccurred at	the time, date	and place	e, and due	to the ca	use(s) and manner state	ed.
	To the within To the compl		29b. Signature and ti	itle of certifier	0				29c. License	number			29d. D	ate signed	(Month,	Day, Year)	
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PATTENT KNOWN AS KEITH J. TURNIPSEED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month la Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk 7237 Stratton Way 8. Date of Birth
(Month, Day, Year)
November 5,1920 If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **Director** 226-12-9220 1 XM 2 □ F 91 Virginia Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 ื No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21224 7237 Stratton Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 Specify:White 1 Yes 2 X No Specify: 3X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Postal Office Clerk 12 vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maggie A Neal Albert L. Tuck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Hammond Lewis Daughter 1162 Ocean Parkway, Berlin, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 12, ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 Donation 5 Other (Specify) 2012 BAltimore, Maryland Ign, ture of Fu teral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 so, or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Li Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence f): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: Te law equires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Year Pregnant at time of death signed by the a I be detached f Yes 2 No Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🛭 Unknown een 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy performe death? 1 Tyes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 2 Accident
3 Suic Natural injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of ertifier 29c. License number 2643 23a) (Type, Print) person who completed cause of death (Item

Registrar

State

Arthur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 8:50 AM HERBERT Moses 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MEMORIAL UNION BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral Director** 1 ★M 2 □ F 62 Yrs. 02/22/1950 show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD BALTIMORE 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? STONEWOOD ROAD 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 X Yes 2 ☐ No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) UPERATOR WR GRACE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ELLA WRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STONEWOOD WIFE UCEAL Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 10/15/12 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUSHN 6REENE FUNERALS CUS 4905 101540 YORK ROAD. BAYIMORE, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ tractory weeks disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Pneumonia Exami 2 weeks Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Obstructive Pulmonary Disease Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 № Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 XN0 ၉ 1 Yes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural injury 5 Pending 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🛛 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signaty**r**e 29d. Date signed (Month, Day, Year) W.P. AT 2438946 October 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital, 201 E. University Pkwy. Chiagozie Ononiwu, M.D. Department of Medicine; Suite 405 33rd st. Bldg.

Baltimore, MD 21218 Registrar's Signatur State parker OCT 1 0 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ Vladimir Vyazemskiy 2012 7:07 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Stella Maris</u> <u>Timonium</u> Baltimore Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Min. (Month, Day, Year) Hours Country) 213-35-2191 **Director** 1 X M 2 □ F 83 Yrs Aug. 23,1929 Usual Residence of Decedent Russia ral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Baltimore Owings Mills 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 221 Owings Gate Court Apt. 103 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give 1 Yes 2 XNo Specify Completed 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+)
5+ Teacher Education permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Isaak Beniaminson Sara Vyazemskiy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Kleopatra Vyazemskiy / wife 221 Owings Gate Court Apt. 103 Owings Mills, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 10/8/12 . Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 tel-M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a. LUNG CANCER Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injury and the cause of the cause o Examine Due to (or as a consequence of) Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burlal-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Mospital or Attending Physician: The law requires that the death certificate bewithin 24 between use after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burners. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Records. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 👿 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No M Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, TIMONIUM, MD 21093

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

2012

2012

OCTOBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month WILL 5:50 AM lamson 20/2 Leo 14 october Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northampton re deri Frederick MUNDR Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min (Month, Day, 20.7490 1 🗆 M 2 🕱 F Hours Director Dec. inia Usual Residence of Decedent 28a-f shov with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland -ve aevi rederic 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code must be Funeral 23a 200 East death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Tes 2 No Specify. "natural" Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Maker Home OWn Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of ည axie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Mever Onzlow G. Williamson Ja Son New Market Maryland Ave 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Department or Important: If any injury or ō 12012 ☐ Donation 5 ☐ Other (Specify) National Cemetery 10 lantico 22. Name and Address of Facility Signature of Funeral Service Licensee Service Robert B Baken Read ARLINGTON, V9-22206 Shirlington 605 80. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) resulting in death) Last physician as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ☐ Pregnant at time of death
☐ Unknown ed by the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? this certificate 2 No Yes To the Hospital or Attending Physician: <sup>1</sup> within 24 hours after death. To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 🗹 No Other 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending ☐ Natural work? 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) mD.

Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# InerPHYS G932 10/16/2012 WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>Yea</sup> Month IO Oneather Wise 06 2:25p.M Juanita Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Future Care Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 1 ☐ M 2 🔀 F Director 220-24-3244 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No MD NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 U.S.A. 4108 Penhurst Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3√ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) <u>Crossing</u> Guard <u>2th grade</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Irvin Johnson Jessie Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6509 Armstrong Ave, Baltimore, Md 21215 Vallorie Sharp-Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 W Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/17/2012 Owings Mills, Garrison Forest Vet Signature of Funeral Service Licensee 22. Name and Address of Facility Wabash Ave Baltimore, t 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line Onset and Death nediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown g 🗌 Unknown completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 41 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No 1 Yes 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann f Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending work' 1 Yes 2 No Accider
Suicide Accident Investigation within 24 hours after deat.

To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Warman 813 egistrar's Signature 31. Date filed (Month, Day, Year) 32 State Registrar

DHMH 17 Rev 7/2009

12-07602 Robert Lee Witt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Lee Witt		Si 1- For State Registrar	tate of Marylan		artment of		l Mental I	, 0	on No. 2	012 3245			
Physicia Medical Exami		Decedent's Name (First, Midd	le,Last) Lee Wit	t.		-		2. Date of Dea Month October 7		3. Time of Death 1115 hrs			
		4a. Facility Name (if not institution 107 Catalfa Avenue				h. City, Town, or L Pasadena	ocation of Dea		4c. County of				
Funeral Director		5. Social Security Number 220–08–5359	6. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24H Hours Mi		th(MM/DD/YYYY)	9. Birthplace (State or Foreign Country) Maryland			
и апу		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Locati	on		02/10/	1712	10d, Inside City Limits			
Maryland r 28a-f sho	Director	Maryland Ann 10e. Street and Number	ne Arundel	Mi1	lersvil	10f. Zip Code	_	11	0g. Citizen of Wh	1 Yes 2 No			
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral D	8449 Woodland F  11. Marital Status  1 Never Married 2 M	12. Was Decede	es?	J.S. 13. Was	2110 s Decedent of Hisp es, specify Cuban,	anic Origin? ( §	Specify Yes or No o Rican, etc.)	U.S.A.  Decify Yes or No- Rican, etc.)  14. Race - American White, etc.				
vurs after de itural", or aminer mu	2	3 Widowed 4 X Div	orced If Yes, Give Year or Dates:	2 X No	16a. Decedent	Yes 2 No	n (Give kind of		Specify:	· WHITCO			
24	Completed	Elementary/Secondary (0-12)	College (1-4 o			ost of working life. Inselor	OO NOT use re	tired)	Drug Re	•			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Robert Lee 19a. Informant's Name/Relations	,		1400 14.30	l <sub>N</sub>	Margare	e (First, Middle, N $$ E .	Dan	iels			
MD id 2 shoulth and m 27 is aumati	- 1	Margaret E. Dar 20a. Method of Disposition	niels (Mothe	20b.	8449	Address (Street a Woodland tion (Name of ceme	Road M		lle, Mar	ryland 21122  City or Town, State			
Baltimore, permit. Pages I ar Department of Hee Important: If ites		1 Burial 2 Cremation 4 Donation 5 Other So 21. Signature of uneral Service	pecify:	State At1	crematory or oth antic C	erplace) remation	10/	09/2012	i	rnie, Maryland			
Physician	3204 Mountain Road Pasadena, Mar y Tan  National Pasadena, Mar y T												
/Medical Examiner		failure. List only one cause immediate Cause (Final disease or condition resulting in death)	on each line.  a <b>Dilated C</b> Due to (or as a cor	ardio	nyopathy					rt Approximate Interval Between Onset and Death			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a cor	nse y lei ne o	r)								
executed an and al - transit	@	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cor		,								
be be	Medical	X UNPENDED  IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outc			r me,g933	3 11–20	-12 sm	23d. Date of d	lelivery			
Box 6876 e death certificate the attending phy led for use as the t	Physician/M	past 12 months?	I Live birth	at time of de	ath =	al death 3 er (Specify)	Ectopic pregn	ancy	Month	Day Year			
ires that the signed by t	2	Part ii. Other significant conditi Obesity	ons contributing to dea	ath but not re	esulting in the un	derlying cause give	en in Part I.			ute to the cause of death?  Probably 4  Unknown			
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Completed							24a. Was a autops perform	ned? pri	ere autopsy findings available for to completion of cause of ath?  Yes 2 No			
of Vital Red Physician: The er this certificate and director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death			ER/Outpatient	3 DOA Ot		ng Home 5 F	Residence 6				
Vision contending of Attending ther death.  Director: Affin by the fun	28a. Date of Injury (Month, Day,Year)  27. Manner of Death  1												
Divisior To the Hospital or Attend within 24 hours after death To the Flueral Director: completely filled in by the													
To the Hos within 24 h To the Fun completely		29b. Signature and title of certifier	niner: On the basis of ex and manner stated	amination ar	nd/or investigatio	n, in my opinion, d	eath occurred a	at the time, date a	nd place, and due	e to the cause(s)  (Month, Day, Year)			
d		30. Name and address of person	who completed cause of	death (Item	23a)	O.C.M.	E.		October 8, 2	012			
Sta			ssistant Medical E		900 W. Ba	Iltimore Street,	, Baltimore,	MD 21223					

ulliams, Name SS Patient Known Baltimore, Maryland

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7:58 P M Warren Douglas Williams, Sr. 201 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ALTEMOR 8. Date of Birth (Mo015/24)./19944 6. Sex X 1 □ M 2 □ F Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** cial Security Numbe 7. Age (In yrs. last birthday) Min. 219-40-5289 Months Hours Cou Waryland 68 **Director** shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Yes 2 ☐ No MD Baltimore 0 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a Funeral 3601 Fords Lane 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene Mechanic Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James S. Williams, Sr.. Lillian Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Warren Douglas Williams, Jr. / Son 3832 Old Birdsville Road, Harwood, MD 20776 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Chesapeake Crematory 10/10/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner was dially list excludity on Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sician and burial-trans that initiated events resulting in death) Last Physician/Medical Box 68760 as the use 8 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a detached i P.O. signed d be dei Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform ☐ Yes 2 🗌 No Division of Vital 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? 으 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury 28h Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, 1 Natural 2 Accident 5 Pending work 4 hours after death. •uneral Director: Aff ely filled in by the fu 1 Tes 2 🗌 No Investigation 6 Could not be 3 Suicide
4 Homicide n 24 hou.. the Funeral Direc. مال filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CROSSRUADS #53 CATONSVILLE, MD V GOLLING State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 27 DM Nola Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Marylad Medical Contro Baltimore Iniousily 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign 50-1267 Hours Director 1 □ M 2 🗹 December 2 1948 (aRolina 28a-f show 10a, State 10h. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 ►Yes 2 □ No MARYLAND DAltimoes 0 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5002 -ONAnt WA 21206 U5A death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Examiner Armed Force 0 1 X Never Married 2 Married 1 ☐ Yes 2 ♣ No If Yes, Give Š within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify: "natural", Completed 3 Widowed 4 Divorced HMERICAN Year or Dates Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Important: If item 27 is marked other than 'any injury or other traumatic event. the Market of the Market other than 'once. Elementary/Secondary (0-12) College (1-4 or 5+) Ech Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna 2 MARIGO lizabeth DILSON 19a. Informant's Name/Pelationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Anthony BAHIMORE 500 Kobinson Conant 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) burney Cremotery October 132012 re of Funeral Service Licen e 22, Name and Address of Facility NAMEY M. WALLACE FUNCTAL 13405 W. FRANKLIN ST. BALL BAHLIMOVE, MARGHAR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart follure. List only one cause on each line. Approximate Interval Between Immediate Cause (F al disease or condition resulting in death) Onset and Death Physician/ laronary Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence burialphysician Physician/Medical USE eaun use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed? Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: ျင 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 — Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 2 No 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Effertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature an 29c. License number

DHMH 17 Rev 06-2011

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Presser

30. Name and address of person who completed cause of death (Item 23a) (Type

2012

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month 09 201<sup>Yea</sup> pm John William Adamecz SR. 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1600 Locksley Drive **Annapolis** Anne <u>Arundel</u> If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 218-12-8831 Director **X**□ M 2 □ F 88 Chicago, IL 05/31/1924 Usual Residence of Decedent 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Anne Arundel Annapolis 1 Yes 2 XNo 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1600 Locksley Drive 21401 USA items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces Black, White, etc. 0 à 1 Never Married 2 X Married X Yes 2 ☐ No Yes, Give ∠ 3. Baltimore, Maryland 21215-0036 res, Give 43-46 Year or Dates, 1 Tes 2 No Specify: oe filed wn....
Mental Hygiene.
'ed other than "nature.
'\* the Medical Ex "natural" 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chief Engineer traumatic event, the Hospital 08 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental P is marked o ည Paul Joseph Adamecz Fosler Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 st tment of Health a tant: If item 27 i Lilliam Adamecz/ Spouse 1600 Locksley Drive Annapolis, MD 21401 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Maryland Veteran's 09/25/2012 Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home P.A.Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a contequence of) Cause (Disease or injury that initiated events resulting in death) Last trar and Due to (or as a consequence of): burialthe attending physician hed for use as the buria Physician/Medical that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death signed by the at d be detached for 1 Yes 2 No g . Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an has autopsy performed? Yes 2 N certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 10 Hospital ျ 4 ☐ Nursing Home 5 Pesidence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA this . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No eral Director: After filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending injury М Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 ause of death (Item 23a) (Type, Print) Name and address of person C State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joyce Elaine Armstrong Day Month Medical Sept 2012 11:36 P.M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 219-58-2706 Months Days Hours **Director** 1 M 2 XF 61 Yrs. 06/12/1951 Wash.,D.C. Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director 10c. City, Town or Location 10d. Inside City Limits Md. Prince George's Bladensburg XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20710 5800 Annapolis Road # 1015 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. <u>۾</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hair dressing Hairstylist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Brown Annie Woodruff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5800 Annapolis Rd. # 615, Bladensburg, Md. 20710 Angela Brown/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory, Inc. 10/01/12 Beltsville, Md. 21. Signature of Funeral Service Licer 22. Name and Address of Facility Henry S. Washington 25 Burroughs Ave., N. nall Sons Co., Inc., Washington, D CC0316 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Priysician Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. y physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending phy of for use es the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month signed by the a lid be detached f Day g 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires th within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a 1 🗌 Yes 2 🔀 No 3 🗌 Probably 4 🗌 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed ☐ Yes 2 🕅 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Yes 2 No Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 9c. License number ss of person who completed cause of death (Item 23a) (Type, Print) 15:11 HAPTOVER FARKUA 31. Date filed (Month, Day, Year) State legistrar's Signatu

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Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 1045 2013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Autumn Assisted Living Washington Hagerstown Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth 1 🔀 M 2 🗆 F Days Hours Min April Day, Director 213-26-0869 88 Maryland ,T924 Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 Cameo Drive 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Black, White, etc. ģ Yes Yes, Give 2 No Maryland 21215-0036 white 1 ☐ Yes 2X No Specify. "natural". 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) register nurse hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F is marked of Charles Vernon Anderson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. injury or other traumatic Mary Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Nutzman - daughter 109 Blackberry Lane, Harpers Ferry, West Virginia Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 25425 Date 1 🗌 Burial 2 🗶 Cremation 3 🗍 Removal from State September Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 2012 of Funeral Service Licensee . Signatur 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Let Examine Due to (or as a consequence of as the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year detached 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Completed 1 Yes No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 🗌 No Accident the Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 28f. Location (Street and Number or Rural Route Number Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie

JW-10+1

State Registrar

DHMH 17 Rev 7/2009

only one) 29b. Signature

31. Date filed (Month

A. K.

of death (Item 23a) Fy

29c. License number

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Phillip Brooks		State of Maryland / Department 1- For State Registrar Certificate			2012 g. No.	3246	
Physici Medical Exami		PHILLIP BLOOKS		2. Date of Death Month October 2,	Day Year 2012	3. Time of Death 0220 hrs	
		4a. Facility Name (if not institution, give street and number)  Harbor Hospital Center	4b. City, Town, or Location of Dea Baltimore		4c. County of Death N/A		
Funeral Director					h(MM/DD/YYYY) 9. Birth 1964 Foreign Cou		
varyland 28a-f show any 1 at once.	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Lo  Maryland Anne Arundel Severn				10d. Inside City Limits 1 Yes 2 No	
th the Maryland 23a or 28a-f sho	Director	10e Street and Number 7888 N. Cartier Court	10f. Zip Code 2 1 1 4 4	10	g. Citizen of What Coun! USA	ry?	
r death wi	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer  Yes 2  No specify:	to Rican, etc.)			
21215-0036 Id be filed within 72 hours after when a light within 72 hours after the light was treated other than "natural", event, the Medical Examiner.	Completed I	Elementary/Secondary (0-12)   College (1-4 or 5+)   during	dent's Usual Occupation (Give kind on most of working life. DO NOT use re		16b. Kind of Business/In		
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medical	Be	17. Father's Name (First, Middle, Last) George Brooks, Sr.	Carol	ne (First, Middle, M Lyn Garn	ner		
MD 2 nd 2 should alth and M in 27 is m	<sup>L</sup>	George Brooks, Sr. (Father) 788	per, City or Town, State, 2	1144			
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		1 E Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	est 10		20c. Location - City or T Annapolis	,	
Physician  Physician		21. Signature of Funeral Service Licensee  22. W 23. Part I. Enter the disease, or complications that caused the death. Do not enter	Name and Address of Facility  Im. Reese & Sor  922 Forest Dr	ive Anna	apolis, Md	. 21401 Approximate Interval	
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Subarachnoid Hemorr  Due to (or as a consequence of):			s, shoot, of float	Between Onset and Death	
All de la company of the latest t	er	Sequentially list conditions, if any, leading to immediate  b. Rupture Aneurysm  Due to (or as a consequence of):					
cecuted and and and and and and and and and an	Examiner	(Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):				-1-	
6 be execut bysician and burial - tra	edical	■ UNPENDED □ AMENDED 23a-b,pt.II,2	7,per me,g932 10-	-25-12 sm			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transi	2 !	Pregnant at time of death	Fetal death 3 Ectopic pregr Other (Specify)	nancy	23d. Date of delivery Month Da	y Year	
ds, P.O. Be equires that the de- een signed by the a	2	Part II. Other significant conditions contributing to death but not resulting in the Narcotic and Alcohol Abuse	e underlying cause given in Part I.		acco use contribute to th		
tal Recor	e Completed	25. Was case referred to medical	26.Place of Death (Check	autopsy perform 1  Yes 2	y prior to cor ned? death?	npletion of cause of	
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	tion: To Be	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 VER/Outpatie  27. Manner of Death 1 Natural 5 Pending  Pending		ing Home 5 R	esidence 6 Other:		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, st	reet, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rura ate)	Route Number, City	
To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurrence one)  2 Medical Examiner: On the basis of examination and/or investign and manner stated.					
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month October 2, 2012	n, Day,Year)	
		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore	, MD 21223			
Sta Regist	-	31. Date filed (Month, Day, Year)  OCT 05 2012  32. Registrar's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 19 monde 40 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Anne Aeunde Glen Burnie If Under 1 Year If Under 24 Hrs.
Pays Hours Min. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 220-48-2575 1 X M 2 □ F 62 11/2/1949 Usual Residence of Decedent MARYLAND ortant: If itam 27 is markad othar then "naturei", or itams 23a or 28e-f show injury or othar traumetic avant, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND ANNE ARUNDEL ODENTON 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 490 NORTH PATUXENT ROAD UNIT #21 21113 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PLUMBING PLUMBER Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy Important: If team 27 is marked oth any Injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARGARET FRIEDLINE HENRY E. BOYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
490 NORTH PATUXENT ROAD UNIT 21, ODENTON, MD 21113 DEREK BOYER/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/25/2012 STEVENSVILLE, MD Signature of Funeral Service Lice 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS t 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. Lived Approximate Interval Between Shock, or heart faild Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Ung Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attanding Physician: The law requires that the death certificate ba executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death
9 Unknown 5 Other (specify) 1 Yes 2 9 Unknown To the Funarel Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Yes 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden 5 Pending 1 Yes Accident 2 No Investigation 24 hours after deat Funarel Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To tha I only one 29b. Signature and title 29d, Date signed (Month, Day, Year) 1053850 OB SE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) **SFP 25** Registrar

Amend #12 per FD Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  AACO Health Dept. 9-21-12 KAH  State of Maryland / Department of Health and Mental Hygiene																
AACO II	Barar IX		For State Registrar	3	tate of ivi	aryiand	Certificate of Death Reg. No. 20   2   3 2 4 6 2									
			Registrar  1. Decedent's Name (First, I	Middle, Last)			Cer	uncai	e or L	eam		2. Date of De	Reg. N	0.201	<u>د</u> ا	3. Time of Death
	Physicia Medic		Johnny 3	J. Bat	Hle							Month		ay 2017	r	1335 M
	Examin	er	4a. Facility Name (if not insti	itution, give street	and number)	,1 C	inti/	4b. City	Town, or	Location o	of Death		4	C. County of De	eath ~ 1	e l
	Funeral Director		5. Social Security Number 265–26–4205	6. Sex	_	e (In yrs. las	st birthday) Yrs.	If Unde Months	Days	If Under: Hours	Min.	8. Date of Bir (Month, Da	y, Year)	(	Birthpla Country	State or Foreign
	f show	tor	Usual Residence of Deced 10a. State 10b. C	ounty	1		, Town or Loc					20]	71		10	d. Inside City Limits
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980	s after death ral", or items Examiner m	þ	11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 □ Div	Married A	Vas Decedent E Armed Forces? Yes 2 2 Yes, Give Year or Dates.	No	1		. /	spanic Orig n, Mexican Specify:	gin? (Speci , Puerto R	ify Yes or No- ican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black		
2-0	"natu	plet		ecedent's Education I highest grade con	on		16a. Deced	ent's Usu	al Occupa	ation uring most	of working		16b.	Kind of Busine	ss/Indu	ıstry
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	Medical		resulting in death)	<b>€</b> a. —	Due to (or as:	a conseque	ence of):								+	
	Examiner	P.	Sequentially list conditions	b. —	R19	pirm.	7007	Fu	110,	7					-	
7	ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Firm Underlying Cause (Disease or injury that initiated events	* <b>*</b> c	Due to (or as a	a conseque	ence ot):								1	
	att cernificate be executed attending physician and for use as the burial-transit	I= I														
876	ng phy as the	Med	IF FEMALE:													
. Box 68760	ed by the attendia detached for use	Physician/Medica	23b. Was decedent pregnar in the past 12 months? 1  Yes 2 No 9 Unknown	1 4	f yes, outcome Live Birth Pregnant a Unknown	2 Fetal	death 3	Ectopic Other (s		y 				23d. Date of Month		y Day Year
P.O.	igned b	by	Part II. Other significant co	onditions contribu	iting to death b	ut not resu	Ilting in the ur	nderlying	cause giv	en in Part I		1				cause of death?
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Records,	ysiciali: ille law is certificate has bidirector, page 2 s	Completed						-				24a. Was auto perfo 1  Yes		prior t death	o com	y findings available pletion of cause of
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	this or	1	1 ☐ Yes 2 🔀 No 27. Manger of Death		1 X Inpati		R/Outpatien		·····	4 L Nu				6 ☐ Other (Sp	ecify)	
ion o	25. Was case referred to medical examiner?  1															
Decretify a gradual of the past 12 months?    FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   1   Ves 2   No 3   Probably 1   Ves																
3	e nost n 24 ho e Fune detely f	Medical	(Check 2 ☐ Med	tifying Physician: dical Examiner: O tifying Nurse Pra	n the basis of e	xamination	and/or investi	igation, in	my opinio	n, death oc	curred at the	ne time, date a	and plac	e, and due to the	e caus	e(s) and manner stated
Ę	withir Comp	-	29b. Signature and title of c		,		<u>,                                      </u>		c. License				29d. D	ate signed (Mo	nth, Da	ay, Year)
			(Ann)	n. Kes	6			1/2	255	915			9	1773		
	5 * W		30. Name and address of po	1 Hes	ted cause of d	eath (Item :	23a) (Type, Pi	rint)	Has	e la	2 /	20	de	1273 ber	DIC	m
	Stat Registra		31. Date filed (Month, Day, )	<sup>vear)</sup> 21 2012	32. Registra	ar's Signatu	ire	a de	<del>7</del>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Clifton Best 9 12:30P M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Hours 579-68-0996 **Director** 1 🕅 M 2 🗆 F 59 5-17-1953 Wilson, NC show 10b. County ms 23a or 28a-f sho must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Hyattsville Prince George's 1 X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA Street 20784 5403 Newton items death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ö þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after **Black** 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n:
any injury or other traumatic event, the Medic (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mavis Hunter Clifton Best, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mavis Best/mother 5403 Newton Street, Hyattsville, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City of Town, State Date 1 X Burial 2 Cremation 3 Removal from State Lincoln Memorial 9-28-2012 Suitland, MD 4 Donation 5 Other (Specify) 21. Signature f Funeral Se 22. Name and Address of Facility Tyrone J. Young Funeral Services 5635 Eads Street, NE Washington, DC 23a. Part 1 ter the disease, or o Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between heart failure. List or Immediate ause (Final Onset and Death Physician/ hemorrhage disease or condition resulting in death) ntracrania Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Unidentifying Cause (Disease or injury Due to (or as a consequence of): and -tran; that initiated events resulting in death) Last Due to (or as a consequence of): physician ar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as 1 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 L 9 Unknown the Unknown signed by 1 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertensionbeen sig should b 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performe Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ္ဝ 1 Inpatient 2 ER/Outpatient 3 E 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29d. Date signed (Month, Day, Year) n 55220 5 .FM

State Registrar 3001 Hospital Drive Cheverly, MD

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh 9932 10-18-12 we State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle | ast) 2. Date of Death Month 09  $^{\text{Day}}16$ Physician/ **2**012 Samuel Matthew Burruss 6:00 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery 1123 Ouebec Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 579-52-1917 1 🛛 M 2 🗆 F 05/01/1938 Washington, DC 74 e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1
▼ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20903 USA 1123 Quebec Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces Black, White, etc. 2 1956-1963 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🄀 No Specify: If Yes, Give Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Master Mechanic Private 12th ge 1 and 2 should be filed wit t of Health and Mental Hygie If item 27 is marked other i Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernard Burruss Rosa Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod. 1123 Quebec Street Silver Spring, MD 20903 19a. Informant's Name/Relationship (Type, Print) Barbara Woodward/Fiance' other 20c. Location - City or Town, State **Suitland** 20a. Method of Disposition 20b. Place of Disposition (Name of Cedarter H46 Introv or other place)

MD Veterans Cemetery permit. Page 1 Department of Important: If it any injury or or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State <del>28</del>/2012 Cheltenham, MD 4 Donation 5 Other (Specify) Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): law requires that the death certificate be executed physician and s the burial-trans Hyperlipidemia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Advanced Chronic Lung Disease Box 68760 38 the attending IF FEMALE: - nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Pregnant at time of death 1 Yes 2 9 Unknown signed by the a g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed Hospital or Attending Physician: The | 24 hours after death. 2X No certificate 1 Yes Yes 2 V No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Yes 2**X** No ည 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after usus... ne Funeral Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 24 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D20129 09/21/2012 4 J.M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Achankunju Chacko Avenue #390 Takoma Park, MD 20912 7610 Carroll 22. Registrar's Signature State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Jomah Boakai 5:25 Рм 2012 September 16. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6008 35th Avenue Hyattsville Prince George's 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours 294-50-0870 **Director** 1 🛛 M 2 🗆 F 69 Yrs September 6, 1943 | Voinjama, Liberia Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ò 23a Funeral 6008 35th Avenue 20782 Liberia hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give **Black** "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Medical Physician Surgeon 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Kungue Ballah Saybah Garwu traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh
t of Health a
: If item 27 is 1706 Flora Lane, Silver Spring, MD 20910 Robert B. Boakai / Son Department of He Important: If it any injure 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 9/29/2012 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) **Examiner** Ischemic and Hypertensive Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Diabetes Mellitus the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death a 🗌 Unknown the 9 Unknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Diabetic Nephropathy 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has je 2 autopsy page certificate 2 X No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\boxtimes$  Residence 6  $\square$  Other (Specify) ျပ this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? injury 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours after death.

To the Funeral Director: After completely filled in by the funer

11

Registrar

Medical

Obiora M. Ogbuawa, M.D., 1615 Rhode Island Avenue, N.E., Washington, DC 20018 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

29b. Signature and title of certifie

29a. Certifier

determined

🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 🗆 Certifying Nurse Pyactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D24523

29c. License number

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

9/18/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 32466 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Virginia Yvonne Bateman eptember 19,2012 8:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign (Month. Dav. Year) Hours Director 214-32-9386 1 🗆 M 2 🛛 F 75 Oct. 30, 1936 Washington, DC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits notified MD Prince George's 1 X Yes 2 No |Greenbelt 10e. Street and Numbe ō 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 22 Ridge Road, #112 20770 USA er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Own Home artment of Health and Mental Hyg ortant: If item 27 is marked othe injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) sateman, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Ernest Bateman Ethel Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Laura Lynn Fendlay / Niece 8102 Springfield Road, Glenn Dale, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial Gardens 9/24/12 Marriottsville, MD Signature of Euneral Service 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Finat Physician. Artery Coronary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Disease ulmonary Obstructive Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami use as the burial-transi Cause (Disease or injury that initiated events Congestive Heart and Due to (or as a consequence of) resulting in death) Last attending physician The law requires that the death certificate be Atria P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_

been signed by the s should be detached has page 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I filled in by the funeral director,

Division of Vital Records,

Physician/Medical þ Completed Be ပ္ Certificate: Medical

in the past 12 month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. examiner? 1 🗌 Yes

25. Was case referred to medical 2 No 27. Manner of Death 1 Natural 5 Pending

Accident 6 🗌 Suicide 3 ☐ Suicide 4 ☐ Homicide

only one

29a. Certifier

Investigation

Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28a. Date of injury (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nus

1 Inpatient 2 KER/Outpatient 3 IDOA

28b. Time of

D0061630

Luck Rd, Lanham

Other:

28c. Injury at

work 1 Tes

26. Place of Death (Check only one,

2 🗌 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

24a. Was an

autopsy perform

1 ☐ Yes 2 🔽 No

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Yes 2 □ No 3 □ Probably 4 □ Unknown

1 Yes 2 No

death?

. Were autopsy findings available prior to completion of cause of

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 4

29b. Signature and title of certifier

82. Registrar's Signature

State

Registrar

3,5M

				For	i icase	State of Ma							_			-101	- a - a-
			1	For State Registrar					tificate					Reg. No	1	2	32461
		Physicia	ın/	1. Decedent's Name (F			-						2. Date of Dea	ath Da	¥ 0		3. Time of Death
	2000	Medic Examin	al	William  4a. Facility Name (if no					4b. City, To	own or	Location	of Death	09		. County of		11:40P M
•	and the same of th	Examin	er	,		ral Hospi	tal				clin	OI DOGG!		:			
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		Director		215-82-1 Usual Residence of D		1 🖾 M 2 🗆 F	52	Yrs.					8-7-19	960	Balt	imore,MD.	
		yland •f show ed at	cto		0b. County		10c. City, T		ation							10	0d. Inside City Limits
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	i i	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by Funeral Director	4 Magnol		ace					218	11		10g. C1		JSA	.,.
	:	death items ner m	Fun	11. Marital Status		12. Was Decedent E Armed Forces?		13. V	as Deceder Yes, specify	nt of His y Cubar	spanic Or n, Mexica	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)		14. Race -	America White, e	
256	36	al", or	d by	1 Never Married 3 Widowed 4		1 Yes 2 If Yes, Give X Year or Dates.	No	1	☐ Yes 2	<b>⊠</b> No	Specify	:			Specify:	Whi	
8	2-0	"natur	plete		15. Decedent's			16a. Deced	ent's Usual	Occupa	ation Juring mos	st of worki	na	16b. K	ind of Busi	ness/Ind	ustry
32	121	thin 72 ene. than '	Com	Elementary/Second		College (1-4 or 5	+)	life. DO	NOT use re	etired)	anng mee		g	0,	wn Bi	ısir	I A S S
215-82-1828	d 2	Iled will Hygis other vent, t	To Be (	17. Father's Name (First	st, Middle, Last)			carp	<i>y</i>		18. Moth	ner's Name	e (First, Middle,			<b>201</b> 1	1000
7	ylar	ld be f Menta arked atic ev	ပ	Bernard	Nicho:	las Burru	SS				Ant	oine	tte Ma	arie	e Pai	noni	
出	Maryland 21215-0036	1 and 2 should be filed within 72 hours after dea 7 f Health and Mental Hygiene. 127 is marked other than "natural", or iten other traumatic event, the Medical Examiner		19a. Informant's Name									Route Numbe				
B	re, l	f Healt f Healt item 2 other		Ornella 20a. Method of Dispos		Gillum-f	20h Plac	e of Disno	sition (Name	of	- 1	Г	Dato	20c L	ocation - C	ity or Tox	wn State
$\wedge$	om.	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ 4 ☐ Donation 5		Removal from State cify)	Firs	etery, crem St St	atory or oth	Cre	e) em.	9-25	-2012	Mil	llsb	oro,	DE.
2340	Baltimore,	permit. Page 1: Department of I Important: If its any injury or of		21. Signatur of Fund	al Service Licer	2 , ,							bage 1				
7		TD = (0 O)		23a. Part 1. Enter the	disease or cor	mplications that a sed	the death. [						eet.Be		in.M	- 1	21811 Approximate
TOD	a. P	hysician/		shock, or heart f Immediate Cause (Fir disease or condition		one cause on cac line	1.										Interval Between Onset and Death
-		Medical Examiner	П	resulting in death)	•	a. Due o (or as a		ice of):									
710	100	-xammer	Jer	Sequentially list cond if any, leading to imm		b. King ha		ice of):									
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9/21/2017		e be executed ysician and le burial-transit	cal Examiner	resulting in death) Las	st	Due to (or as a RAID) of a		• '									
8		cate p				■ d	NYY VO	11(914						_			
200	89 ×	deain centificate ne attending phy ed for use as the	an/M	IF FEMALE: 23b. Was decedent pr		23c. If yes, outcome			Ectopic pre	egnanc	v				23d. Date		
	Вох	the att	ysici	in the past 12 mc 1 ☐ Yes 2 ☐ I 9 ☐ Unknown	No	4 ☐ Pregnant a 9 ☐ Unknown	t time of dea	ith 5	Other (spe	cify)					Mont	h	Day Year
00	P.O.	Attending Prlysician: The law requires man the death certificate in death certificate, actor. After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med			contributing to death b	ut not resulti	ing in the u	nderlying ca	use giv	en in Part	: I.	23e, Did to	obacco ı	use contrib	ute to the	e cause of death?
191	ds,	quires 1 en sigr ould be	ed b	DAN Ty	pr 12								1 🗆	Yes 2	□ No 3	☐ Prob	ably 4 Nunknown
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08/07/1900	I Re	sician: The law is certificate has bilirector, page 2 s		25. Was case referred	to medical					26 Dia	and of Day	ath (Check	1 🗆 Yes	2 <b>2</b> N	0 1	Yes :	2 🗆 No
	Vita	ysrcial is certi	To Be	examiner?		Hospital:	ent 2 🗆 EF	₹/Outpatien	t 3 🗆 DOA	Otho	ar.		me 5 Resid	dence 6	3 ☐ Other	(Specify)	
DOB	of of	ding Pnys h. After this funeral di			5 Pending	28a. Date of inju (Month, Day		3b. Time of injury	- 1	c. Injury work	?		28d. Describe h	now injur	y occurred		
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- 0	Divi	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		4 🗆 Homicide	determined	building, etc	. (Specify)						City or Tou				
X 55		Hospin 24 hour Funera	Medical	(Check 2	Medical Exar	ysician: To the best of miner: On the basis of each	xamination a	nd/or invest	igation, in my	y opinio	n, death c	occurred at	the time, date a	and place	e, and due t	o the cau	se(s) and manner stated.
E	:	Io the within 2 Го the сотре	ž	only one) 3 L 29b. Signature and titl		rse Practitioner: To the	e best of my	knowledge,		-	ne time, da number	ate and pla	ace, and due to t		e(s) and ma te signed (		
Burry		7, 0							HU	006	888	14		9	21/	20	12
	1.	1 ( )		30. Name and address	of person who	completed cause of d	eath (Item 23	Ba) (Type, P	at on Al				DI BE	7100	1 11	0 :	21811
lliam	D.	Sta	te	31. Date filed (Month,	Day, Year)	32. Registra	ar's Signature		1001	701	r=4/+(	V 17117	0.00	2-(1	4,775	4	101/
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3	DHM	H 17 Rev 06-:	2011			,		~									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Helene Leann Burroughs 18, 2012 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 577-42-9874 78 Director 1 M 2 X F Nov. 21, 1933 Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits "natural", or Items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States Funeral 20852 4804 Creek Shore Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Š Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Give Specify: White 3 Divorced Completed Year or Dates al Hygiene. d other than "natura event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Betty Steinhauer Lawrence Buser permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic s 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4804 Creek Shore Drive, Rockville, MD 20852 Paul Hampton Burroughs (Spouse) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Metropolitan September 19, 2012 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Alexandria, Virginia DeVol Funeral Home, Signature of Funeral Servi 22. Name and Address of Facility 10 E. Deer Park Drive, Gaithersburg, MD 20877 M00689 Approximate Interval Between Onset and Death Pnysician/ Medical resulting in death) Due to (or as a consequence of): Pulseless Electrical Activity Arrest Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Pneumonia Exami Due to (or as a consequence of): After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial Physician/Medical Non ST Segment Elevation Myocardial Infarction yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate by Funeral Director: After this certificate by Funeral Director. 1 Yes 2 No 1 ☐ Yes 2 🖾 No Burroughs, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖵 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural injury 5 Pending М 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou **To the Fune** completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 L To the 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 18/12 1165312 MI) 10

Registrar DHMH 17 Rev 06-2011

State

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Sudarshan Siva, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signature

31. Date filed (Month, Day, Year)

SEP 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32469 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09/12/201 Physician/ JAMES EDWARD BOWENS 9:20 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville 5910 Lemay Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/12/1921 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Months Hours Director 225-20-6139 11√ M 2 □ F 91 r than "natural", or Itema 23a or 28a-f shov the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5910 Lemay Road 20850 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married چ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed Specify: 3 Widowed 4 Divorced r Yes, Give Year or Dates. 1943–1946 Black 15. Decedent's Education 16a. Decedent's Usual Occupation Decedent's Usual Occupation (Give kind of working life. DO NOT use retired) ROCKVILLE 16b. Kind of Business/Industry (Specify only highest grade completed) ng most of working of Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver-12th Crushed Stone Transportation 8 Department of the state of the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Bowens UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5910 Lemay Road, Rockville, MD 20850 Myrtle Bowens/wife
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 9/21/2012 Rockville, MD 4 Donation 5 Other (Specify) Parklawn Memorial Pk 22. Name and Address of Facility Snowlen Funeral Home Signature of Funeral Service Lion 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. Insulin dependent Diabetes Mellitus
Due to (or as a consequence of): ase or condition <u>10 vears</u> Medical resulting in death) Examiner Coronary Artery Disease 4 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial transition. Asthma 15 years Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 😾 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marner as stated 29c. License number 29d. Date signed (Month, Day, Year, D32817 September 13, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2016 Georgia Avenue, Wheaton, MD 20902 M. Waieed Khan Μ. 31. Date filed (Month, Day, Year) SEP 2 0 2012 62. Registrar's Signature State

Registrar

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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	-	For State Registrar		State of N	nar yları	•	tificate of L		, ,	Reg. No. 2	112	32470
Physicia	n/	1. Decedent's Name	(First, Middle, I	Last)					2. Date of Dea	th	Year	3. Time of Death
Medic	al	Helen Ar		BOWERS						23, Day 20		7:30 p. <sup>M</sup>
Examin	er			ted Living				Location of Death			nty of Death hingt	
Funeral		5. Social Security Nu			ge (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	1	9. Birtl	hplace (State or Foreign
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lland f shov	tor	10a. State	10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
e Mary r 28a-	Director	Maryland 10e. Street and Num		gton		Hage	erstown			-		1 Yes 2X No
with th	erall			otomac Str	20+		10f. Zip Code 217	40		10g. Citizen o		untry?
death vitems	Funeral	11. Marital Status	South_F	12. Was Decedent	Ever in U.S		Was Decedent of Hi	ispanic Origin? (Spanic, Mexican, Puerto		14. R	ace - Amer	ican Indian,
after or samir	d by	1 ☐ Never Marrie 3 ☒Widowed 4		If Yes, Give	No No		Yes 2 X No		1110411, 0101/	Speci	lack, White <i>ify:</i> 1.71-	nite
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d be fil Jental arked titic ev	유	Frank Se	everio l	Mazzo				Bertha 1			,	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Nar	me/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a	and Number or Rura	al Route Number	City or Town	, State, Zip	Code)
and 2 Health tem 27		Michael 20a. Method of Dispo		ers	20h Pl	•	Gilbert sition (Name of	Hills Dr:	ive, Hag <sub>Date</sub>	erstow 20c. Location		
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ermit. F		21. Signature of Fun			probe	22	. Name and Addres	ss of Facility Mi	nnich Fu	neral	Home	-
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Thusisian/		shock, or heart Immediate Cause (F	t failure. List onl	omplications that cause y one cause on each li	ne.	_		g, such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)		Due to (or as		ence of):	2106				$\rightarrow$	MOVETUS
Examiner	_	Sequentially list con	nditions,	b. STATUS	s Pos		ROKES	(MUL	riale)			MONTHS.
ed nsit	Examiner	if any, leading to impose cause. Enter Underl Cause (Disease or ii	mediate lying	Due to (or as	s a consequ	ence of):			•			MONTHS.
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g Phy er this neral di	te: To	27. Manner of Death		1 ∐ Inpa 28a. Date of in (Month, D	jury	ER/Outpatier 28b. Time of injury	28c. Injury	4 □ Nursing Ho	ome 5 ∐ Resident 28d. Describe ho			MY ASSISPED LIVING
tendin leath. or: Aft the fur	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending Investiga 6 Could no	tion				? Yes 2 □ No				
lor At after o Direct		4 Homicide	determin	28e. Place of Ir	ijury - At hor tc. <i>(Specify)</i>		eet, factory, office		28f. Location (Sa City or Town		ber or Rura	al Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical		Certifying P	hysician: To the best of	of my knowle	edge, death o	occured at the time,	, date and place, ar	nd due to the cau	se(s) and mar	ner as stat	ted. ause(s) and manner stated.
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Stat Registra	_	on. Date med prioriti	SEP 25	/ / 2	rars Signati	1.	and I					

aroline Bowen	State of Maryland / Department of Health and Mental Hygiene								
aronno bowon		1- For State		te of Death	na McMai i		201	2 3247	
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)				2. Date of Deat	th	3. Time of Death	
ledical Exami		Caroline Bowen				Month Septembe		1803 hrs	
		4a. Facility Name (if not institution, give street and number) 1270 England Creamery Road		4b. City, Town, o	or Location of Deat	h	4c. County of Deat Cecil	h	
			(In yrs, last birth			s 8 Date of Bird	th (MM/DD/YYYY) 9. Bi	rthplace (State or	
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		Usual Residence of Decedent				12,21	71330	121	
v any		10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits	
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Mary r 28a- ed at	Director	10e. Street and Number		10f. Zip Code		10	Og. Citizen of What Cou	intry?	
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n 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+)				j 17 <b></b>		
withi withingrene.	mo	17. Father's Name (First, Middle, Last)	wr	iter	18, Mother's Nam	e (First Middle M	Writing	··	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Laurance Bowen				ger Bodei	•		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f shr injury or other traumatic event, the Medical Estminer must be notified at once	To	19a. informant's Name/Relationship (Type, Print )	19b.	Mailing Address (Stre	et and Number or	Rural Route Num	ber, City or Town, State	e, Zip Cooe)	
MD ad 2 sho ulth and m 27 is aumati		Richard W. DeMott/companion					Rising Sun,		
ore, sslan of Hea If iter		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State		Disposition (Name of c ry or other place)	emetery,	Date	20c. Location - City or	Town, State	
iment properties		4 Donation 5 Other Specify:	St. Th	omas Cemet			Fort Washi		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee		22. Name and Addres	ss of Facility R. 7	Foard	Funeral Ho	me, P.A.	
Physician	-	3a. Part I. Enter the disease, or complications that caused t	he death. Do not				ng Sun, MD	Approximate Interval	
Medical	1	failure. List only one cause on each line.						Between Onset and Death	
Examiner		Immediate use (Final disease or condition resulting in death) a. <b>Doxepin To</b> Due to (or as a consection)							
	Ļ	Sequentially list conditions, b.							
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	Medi	IF FEMALE: 23c. If yes, outcome		70			23d. Date of deliver	<u> </u>	
587 ertifica ding pl	an/l	3b. Was decedent pregnant in the past 12 months?	2 [	Fetal death 3	Ectopic pregn	ancy		Day Year	
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  The the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Medical	1 Yes 2 No 9 ✓ Unknown 9 Unknown	ime of death 5	Other (Specify)					
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Division of Vital Records, rat or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should be a bey the funeral director.	Completed					24a. Was a autops		topsy findings available completion of cause of	
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ivisior or Attendather death Director:	cati	2 Accident Investigation fd 9-23		n, street, factory, office		on presc	iption med	ication  Iral Route Number, City	
Divi	Certification:	Suicide Could not be	esidence		building, etc.	or Town, St	ate) 1270 Engl	and Creamer	
Hospit 4 hour Funer ely fill		4 Homicide  29a. Certifier 1 Certifying Physician: To the best of my			date and place, and				
Division To the Hospital or Attend within 24 hours after death The the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of exam and manner stated.							
F 3 F 3	ž	29b. Signature and title of certifier		29c. Licen			29d. Date signed (Mo	nth, Day, Year)	
		after Bull MD		0.C	.M.E.		September 24, 2	012	
		30. Name and address of person who completed cause of de Melissa Brassell, MD Assistant Medical		OO W Baltimore	Street Raltima	re MD 2122	3		
		Melissa Brassell, MD Assistant Medical  31. Date filed (Month, Day, Year)  32. Registrar		ou vv. Dailimore :	oneer, Dailling	17 Z 1 Z Z			
St	ate	7. Registrat	- Signation	0. 10					

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State of Maryland / Department of Health and Mental Hygiene

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Thomas A. Benn	·	tt, Jr. State of Maryland / Department of Health and Mental Hygiene 20123241  1- For State Registrar Certificate of Death Reg. No.										
Physicia	ın/	1. Decedent's Name (First, Middl		T.,				2. Date of Dea	th Year	3. Time of Death		
Medical Exami	ner	Thomas Arno			1.	4b. City, Town, or L	ocation of Death	Septembe	er 24, 2012	1852 hrs		
		Easton Memorial Hos		20.7		Easton			,	Talbot		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	_	` II	Birthplace (State or Foreign		
Director		212-06-4718	1 X M 2 F		45 Yrs		Tiodis Iviii.	09/24	/1967	country) Maryland		
any .	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Locat	ion			-	10d. Inside City Limits		
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Marylz	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	t Country?		
death with the Maryland or items 23s or 28s-f show must be notified at once.		27372 Sandtown		cedent Ever in U	1 12 W	21636	anic Origin? / Sn	ecify Ves or No	USA	American Indian Black		
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after dans, or	by Fr		orced If Yes, Give Yes	ar	1	Yes 2 X No	specify:		Specify:	White		
hours natur	<u>8</u>	15. Decedent's Education (Specific Elementary/Secondary (0-12)	cify only highest gra-			it's Usual Occupation ost of working life. I			16b. Kind of Busi	ness/Industry		
36 hin 72 e.	Completed	12 H.S. Grad.	College (	1-4 (4 (5+)	Weld	er		Metal fabricator				
5-0036 iled within 7 Hygiene. I other than		17. Father's Name (First, Middle,		C >-	٠				rst, Middle, Maiden Surname) Jouise Dodd			
2121 ould be fill marked ic event,	B B	Thomas Arnold  19a, Informant's Name/Relations		51.	19b. Mailing	Address (Street				State Zip Code)		
MD 2 shou th and N a 27 is n unatic	의	Delinia Berger				Sandtown				land 21636		
Feb. I and FHealt Fitem	- 1	20a. Method of Disposition  1 Burial 2 X Cremation	ity or Town, State									
Pages Pages nent of		4 Donation 5 Other Sp			Dover, Delaware							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21 Preparature of Funeral Service	Licensee		22. N	uneral Ho ton, Mary						
Physician	$\dashv$	23a. Part I. Enter the lisease, or failure. List only one cause	complications that of	aused the death		South 2n						
/Medical Examiner		Immediate Cause (Final disease	a Mixed d			0xycodone	,and Fe	ntany1)	Intoxicat			
3		or condition resulting in death)	Due to (or as a b.	consequence of	of):							
	<u>je</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of	of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	of):	-						
(0, e be executed ysician and burial - transit	삤	TT	d	220 27 5	290 f 2	- mo c02	2 10 17	12 am				
30, te be ex sysician	ledical	X UNPENDED  IF FEMALE:		outcome of pred		r me,g93 7-12 sm	2 10-17-	-12 SM	23d. Date of de	elivery		
68761 certificate nding phy	ल	23b. Was decedent pregnant in the past 12 months?	e 1 Live t	oirth	2 Fe	tal death 3	Ectopic pregna	ncy	Month	Day Year		
Records, P.O. Box 68760. The law requires that the death certificate cate has been signed by the attending physpage 2 should be detached for use as the b	hysici	1 Yes 2 No 9 Uni	nown 9 Unkn	nant at time of do own	eath 5 Ot	her (Specify)						
O. E at the d by the stacked	<u>~ </u>	Part II. Other significant condit	ons contributing to	o death but not i	resulting in the u	ınderlying cause giv	ven in Part I.			ute to the cause of death?		
cords, P.O. law requires that the has been signed by 2 should be detach	ed by									Probably 4 🗹 Unknown		
of Vital Records, g. Physician: The law requir ther this certificate has been s meral director, page 2 should l	Completed							24a. Was autop	sy pri	ere autopsy findings available or to completion of cause of ath?		
Rec The la	S							1 Yes	2 No 1	Yes 2 No		
rital sician: is certil	å	25. Was case referred to medica examiner?		Inpatient 2 🗸	ER/Outpatient		of Death (Check of Death (Chec		Residence 6	Other:		
of Vital Reculus Physician: The Land After this certificate fineral director, page	٢	1 Yes 2 No 27. Manner of Death	28a Date		28b. Time of I		at Work?	28d. Describe	how injury occurred			
e ii ii di ⊐	atio	1 Natural 5 Pend 2 X Accident Inves	tigation fd 9	9-24-12	fd 175.	o hrs	- (25)			dications		
Division tal or Attendi rs after death.	Certification	dete	d not be mined (Specify)		nome, farm, stree sidence	et, factory, office bui	ilding, etc.	or Town, S	tate) 27372	or Rural Route Number, City Sandtown Rd.		
Divisio To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th		4 Homicide	nysician: To the be			red at the time, date	e and place, and	Goldsbo		s stated.		
o the lathin 2 to the loomplet	Medical	Check only	miner:On the basis and manner s	of examination a								
F S H S	ž	29b. Signature and title of certifie		X	4 25	29c. License				(Month, Day, Year)		
	ļ	IN			(V)	O.C.M	1,⊆.		September 2	.U, ZUIZ		
		30. Name and address of person Russell Alexander MD		A /		W. Baltimore S	Street, Baltim	ore, MD 21	223			
		31. Date filed (Month, Day, Year)	32. R	egistrar's Signat								
Regist	rar											

12-07089 Kenneth Wallet Cra	otate of Maryland / Department of Fleath and Mental I	lygiene
	1- For State Certificate of Death	Reg. No. 2012 3247
Physician/ Medical Examine	Kenneth Wallet Crandell, Jr.	2. Date of Death Month September 19, 2012  3. Time of Death 2328 hrs
	4a. Facility Name (if not institution, give street and number)  Prince George's Hospital Center  4b. City, Town, or Location of Dea  Cheverly	th 4c. County of Death Prince George's
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H. Months Days Hours Mi	1_
v any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
the Maryland  or 28a-f show tified at once	MD Prince George's Clinton  10e. Street and Number 10f. Zip Code	1 Yes 2 No
ith the M  23s or 2  notified		USA
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "untural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married  1 N	specify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: Black
72 hours aft "natural" al Examine	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	work done 16b. Kind of Business/Industry
215-0036 be filed within 72 houn ntal Hygiene. riced other than "nath ent, the Medical Exa Be Completed	1 year I.T. specialist  17. Father's Name (First, Middle, Last)  18. Mother's Name	Navy e (First, Middle, Maiden Surname)
21215 ould be file d Mental Hy s marked o tic event, th	Kenneth W. Crandell, Sr. Clara I	aVerne Bell  Rural Route Number, City or Town, State, Zip Code)
, MD ; and 2 show saith and em 27 is raumatic	Clara LaVerne Bell/Mother 11130 Piscataway Road  20a. Wethod of Disposition   20b. Place of Disposition (Name of cemetery,	Clinton, MD 20735
Baltimore, permit. Pages I a Department of He Important: If ite	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  20. Trace of Disposition (Name of Centerly, crematory or other place)  Trinity Baptist Church 9/	and a second only of rount, out
Balti permit. Departn Import injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mar	shall-March Funeral Home Suitland, MD 20746
Physician Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries	or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
Examiner	or condition resulting in death)  Due to (or as a consequence of):	
ted nsit	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c	
executed an and al-transit	events resulting in death) Last Due to (or as a consequence of):  d.	
50, te be ex ysician burial	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  Ithe Funeral Director: After this certificate has been signed by the attending physician and oppletely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Physician/Medical Ex	FFEMALE:   23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1	23d. Date of delivery ancy Month Day Year
P.O. B es that the d igned by the detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, ag Physician: The law require ther this certificate has been signeral director, page 2 should b n: To Be Completed		24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical 26. Place of Death (Check	1 ✓ Yes 2 No 1 ✓ Yes 2 No
ing Physici ing Physici After this c uneral dire		ng Home 5 Residence 6 Other:
ion of tending Ph tending Ph death. stor: After i the funeral	27. Manner of Death  1  Natural 5  Pending 2  ✓ Accident  Pending 1  Pending  Pendi	28d. Describe how injury occurred Operator of motorcycle -motor vehicle collision
Division o spital or Attending tours after death. meral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 4500 block Paint Branch Parkway, College Park, MD
Divisi To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
F 3 F 3	29b. Signature and title of certifier  29c. License number  O.C.M.E.	29d. Date signed (Month, Day, Year) September 20, 2012
SIM	30. Name and address of person who completed cause of death (Item 23a)  Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	
State Registrar	<i>J</i>	,
DHMH 17 Rev 1/2001	OGME ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Blanche. Marie Cook Month 9 4:21 201 рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Clinton Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Hours 241-34-2108 87 Director 1 M 2 X F 2/4/1925 SouthCarolin 10c. City, Town or Location Clinton th and Mental Hygiana. 27 is marked other than "netural", or Items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 10b. County within 72 hours aftar daath with the Maryland 10d. Inside City Limits Directo Md. Prince Georges 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9600 Stuart Lane 20735 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Specify 3 🖾 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sims Eddie Lee and 2 should ba Lillie Mae Sims 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Haalth Eltem 27 i Kallima Mustapha Gray-6583 Pennsylvania Ave. Forestville, Md. 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dapertmant of I Important: If Ite eny injury or ot once. 1 Durial 2 Cremation 3 Removal from State Heritage Cemetery 9/20/12 Waldorf, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Universal Mortuary asen Kennedy St. NW Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Sit sicien and burlal-tra that initiated events Due to (or as a consequence of): resulting in death) Last tha ettending physicien ched for usa es the burla Physician/Medical Physician: The lew requires that tha daath cartificate ba Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) To the Hospital or Attending Physician: The lew requires that tha daa within 24 hours after death.

To the Funeral Director: After this cartificata has baan signed by tha e completaly fillad in by the funerel director, page 2 should be datached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 / Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending **☑** Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and the of gertifier 29d. Date signed (Month, Day, Year) anne 00055120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIGHMOPALMER avenu SE Suk 310 31. Date filed (Month, Day, Year) State SEP 20 Registrar

12-06968 Dean A. Collins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 32475 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Antonio Collins **Medical Examiner** Dean 0348 hrs September 15, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Min 216-92-3138 1X M 2 F 33 Yrs March 9, 1979 Country) Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. MD Wicomico Salisbury permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No rector 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Ö 730 Meadow Wood Drive 21801 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 White, etc. 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Yeer Black 1 Yes 2 X No specify: Specify: ş or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12 Truck Driver Waste Removal 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) David Ayres Charlene Collins ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charlene Collins/mother 730 Meadow Wood Dr., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Itimore, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Green Acres Mem Park 9/22/2012 Salisbury, MD Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 **Physician** 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line /Medical Between Onset and a. Head Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as e consequence of) cause. Enter Underlying Cause e or injury that initiated Due to (or as a consequence of): events resulting in death) Last ician/Medical attending physician for use as the burial UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Physi ģ Completed

Hospital or Attendiog Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the within 24 hous.

BB

Certification: To

Medical

State

Registra

29b. Signature and title of certifier

Carol H. Allan, MD

31. Date filed (Month, Day, Year)

past 12 months?  1 Yes 2 No 9 Unknown	Pregnant at time of d	eath 5 Other (S		lancy	Month Day Year
Part II. Other significant conditions	contributing to death but not	resulting in the underly	ing cause given in Part I.	23e. Did tobacco u	ise contribute to the cause of death?
		···		1  Yes 2 ✓	No 3 Probably 4 Unknown
CAUR-				24a. Was an autopsy performed? 1 Yes 2 ✔ No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical examiner?			26. Place of Death (Check		
1 ✓ Yes 2 No	ospital: 1 🗸 Inpatient 2	ER/Outpatient 3	DOA Other Nurs	ing Home 5 Resider	ice 6 Other:
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day Year) Sep 5, 2012	28b. Time of Injury UNKNOWN	28c. Injury at Work? 1 Yes 2 № No	28d. Describe how injur	
3 Suicide 6 Could not be determined		iome, farm, street, facto id / Highway	ry, office building, etc.	28f. Location (Street an or Town, State) Route 50 at Ward Str	d Number or Rural Route Number, City reet, Salisbury, MD
29a. Certifier (Check only one)  2  Medical Examiner:	nn: To the best of my knowled On the basis of examination a	dge, death occurred at t	he time, date and place, an my opinion, death occurred	d due to the cause(s) and at the time, date and place	manner as stated.

29c. License number

OCME

900 W. Baltimore Street, Baltimore, MD 21223

To the

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

OCWE

Vaca

32. Registrar's Signature

1 waren

29d. Date signed (Month, Day, Year)

September 16, 2012

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle, Last) 2. Date of Death Physician/ SEPT 19<sup>ay</sup> 2012<sup>a</sup> 12:14A M RICHARD GLENN CUMINGS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY ROCKVILLE SHADY GROVE HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Days Hours Country) 618,61 85 Director 579-24-7501 1 MM 2 DF Vre 10/11/1926 CO Usual Residence of Deceden 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location in then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland Director 1 ☐ Yes 2 M No MONTGOMERY ROCKVILLE MD September 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20853 13912 DRAKE DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Culpan, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No1 9 4 4 -Black White etc. ģ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1946 Specify Specify: WHITE 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ns any injury or other traumatic event, the Madis once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) ENGINEER **AEROSPACE** ELECTRONIC 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WINIFRED WENKHEIMER GLENN A. CUMINGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13912 DRAKE DR., ROCKVILLE, MD 20853 JANE CUMINGS / SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State STAUFFER CREMATORY 09/21/2012 FREDERICK, 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. BOX 86 - HM HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ anoxic ence ha lorath disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner death cardiac Sudden Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence or, Exami cardiovascular After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use es the burial-trensit atherosclerotic Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Denpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerei Director: Aft completely filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D00+0022 70 'ox' 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Man land 20800 9,901 Medical Center Drie Rockville, LUORID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State RECEIR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Am	end	#26, per	<b>Pleas</b> verbal	e <b>Type or Pr</b> g932 10/9 State of N	r <b>int in</b> /12 t /larylan	Black I rt id / Dep	ndelible In artment of	i <b>k. Ensu</b> i Health ar	re All Cop nd Mental I	ies Ar	<mark>e Legi</mark> l e	ble.	- 01 7	7
		-	State Registrar					rtificate of			Reg. N	200	12	3247	İ
	Physicia	<b>1</b> 0/	1. Decedent's Name							2. Date o	f Death		Voor	3. Time of Death	$\neg$
	Medic	cal			ee Crockei						- 1	<sup>22</sup> 22 20		10:22 P M	0
رياستور ماميد	Examir		Frederi	ick Memo	rial Hosp	ital			derick		1	rede	rick		
	Funeral Director		<ol> <li>Social Security Nu</li> <li>217–30–6520</li> </ol>	<u> </u>	Sex 7. A	ige (In yrs. Ii <b>79</b>	ast birthday)	If Under 1 Year Months Days		Min. (Month	, Day, Year)		Coun		n
			Usual Residence of		I L M Z IAJ F	- 13	Yrs.		1_1	Februa	ry 10,	1933	Wash	ington DC	
	yland f sho ed at	햦		10b. County		10c. Cit	y, Town or Lo						1	0d. Inside City Limits	
	Mar 28a- notifie	Director	Maryland  10e. Street and Num	Frede	erick				Frederick	<u>.                                    </u>	T			1 ☐ Yes 2 🛣 N	0
	ith th	ra I	5813 Meador					10f. Zip Code	21702		1	Citizen of Wh		of America	
	ems :	Funeral	11. Marital Status	M DIIVE	12. Was Deceden	t Ever in U.S	S. 13.			n? (Specify Yes or		14. Race			긕
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  By increastri if the Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medicel Examiner must be notified at once.	<u>۾</u>	1 ☐ Never Marrie 3 ☐ Widowed 4		Armed Forces	?		Was Decedent of HI Yes, specify Cub		Puèrto Rićan, etc.)			White,	etc.	
5-0	2 hou "natu	Completed	(Spec	15. Decedent's cify only highest of	Education grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin					16b. Kind of Business			dustry	
12	ithin 7 ene. than he Ma	튅	Elementary/Secon	ndary (0-12)	College (1-4 or <b>5+</b> -	r 5+)		00 NOT use retired Iomemaker	0	-		Own. H	0000		
d 2	led wi Hygir other ent, t	8	17. Father's Name (F	irst, Middle, Last,			1 1	OHEHAKEL	18. Mother's	s Name (First, Mic	ldle, Maider		ome		_
lan	d be fi //enta rrked rtic ev	잍	Freeman V	Walker Cha	apman				Rebec	ca Minnie	Mantz				
ar)	should and N is ma euma		19a. Informant's Nar	me/Relationship	(Type, Print)		19b. Maili	ing Address (Street	t and Number of	or Rural Route Nu	mber, City o	or Town, Sta	te, Zip (	Code)	
≥	ind 2 : lealth rm 27 her tr		Russell A.		Husband			Meadow Dri	ive, Free	derick, Mar					_
ore	ge 1 a t of F : If ite or ot			Cremation 3	Removal from Sta	te c	emetery, cre	osition (Name of matory or other pla	ce) Ś	eptember 27, 2012	20c.	Location - C	•		
턆	iit. Pa artmer ortant injury	П	4 ☐ Donation  21. Signature Fun	5 Other (Spec	**	Rest		Memorial Ga				rederic	K, M	aryLand	$\dashv$
Ba	Depar Depar Impor any ir		21. Signature i Fun		nige <del>c</del>	MO		Address & Barrier & Barrier & Barrier & Barrier & Co. 106 East Co. 106				Marry 1 a	nd 21	701	
					mplications that caus	ed the deat						TELLY LO		Approximate	П
	hysician/		Immediate Cause (F disease or condition	inal	one cause on each li									Interval Between Onset and Death	- 0
	, Medical Examiner		resulting in death)	•	Due to (or a	-	uence of):						$\neg$		
	Exammer	<u>ا</u>	Sequentially list con	nditions,	b. —								_		_
	ed Isit	Examine	if any, leading to imr cause. Enter Underl Cause (Disease or in	ying <b>E</b>	Due to (or a	s a consequ	uence of):								
	s executed tian and urial-transit		that initiated events resulting in death) L		C. Due to (or a	s a consequ	uence of):						+		$\dashv$
	s be e /siciar e buri	ical		- l	■ d										
Box 68760	Attending Physicien: The law requires that the death certificate be actor. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the bit is a first or the bit is a signed by the funeral director.	Physician/Medica	IF FEMALE:					· · ·			1		. 1		$\exists$
<u>ن</u>	tendir tendir	ian/	23b. Was decedent p		23c. If yes, outcom 1 \subseteq Live Birth	2 🗍 Feta	aldeath 3	Ectopic pregnar	псу		- 1	23d. Date			
8	the at the at	ysic	1 Yes 2 2 9 Unknown		4 ∐ Pregnant 9 ☐ Unknowr		death 5 L	Other (specify)			-	Mont	n	Day Year	
Division of Vital Records, P.O.	ed by detac	된	Part II. Other signific	cant conditions	contributing to death	but not res	sulting in the	underlying cause g	jiven in Part I.	23e. [	oid tobacco	use contrib	ute to th	e cause of death?	
S,	n sign lid be	ed by								1	☐ Yes 2	2 <del>□</del> No 3	Prot	oabły 4 🗆 Unknow	'n
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Bec	Ine ia ate ha page	틵									utopsy performed? res 2 1	de	ath?	mpletion of cause of 2  No	
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<b>E</b>	rnysicien: The law this certificate has ral director, page 2	욘	1 ☐ Yes 2 🗷					ent 3 LI DOA		sing Home 5 🗆 F				)	_
ם ס	After After	Certificate:	27. Manner of Death 1 Natural	5 Pending	28a. Date of in (Month, E		28b. Time o injury	wor			be how inju	ury occurred			
Sio	after deat  Director:  In by the	Ě	2 Accident 3 Suicide 4 Homicide	Investigati 6 Could not determine	be 280 Place of I	njury - At ho	ome, farm, st	reet, factory, office			on (Street a	and Number	or Rural	Route Number,	$\dashv$
	5 # E = 1		4 🗆 Honlicide	determine	building, e	etc. (Specif)	)				Town, Stat				
7	Hospital or 24 hours afte Funeral Dir stely filled in	Medical	29a. Certifier 1 (Check 2	Certifying Ph	nysician: To the best miner: On the basis of	of my know	ledge, death	occurred at the tin	ne, date and pl	lace, and due to the	ne cause(s)	and manner	r as state	ed.	tod
	io the hospital or Attending Pri within 24 hours after death.  To the Funeral Director. After thi completely filled in by the funeral	Ş	only one) 3	Certifying Nu	rse Practitioner: To	the best of r	ny knowledge	e, death occurred at	the time, date	and place, and due	to the caus	se(s) and ma	nner as s	tated.	ieu.
	<b>2</b> ≥ 6 8		29b. Signature and ti	arul				29c. Licens	se number D 6 7 7 3	67)	29d. D	ate signed (			
U			, who					1110	V 4 / /3			$\sim$ 1,	23	1,2012	
			30 Name and addish	ss of person who	completed cause of	death (Item	23a) (Time	Print)							
		B	30. Name and addres	ss of person who	o completed cause of	death (Item	1 23a) (Type,	Print)  DEKICK	mo	2170	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1>-7117 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Sept 3 Time of Death Day 20 Physician/ Nilliam Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Univ of MD Medical Center Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State of Foreign Hours 217-28-0158 Director 1**XX**M 2 □ F 80 Dec. 29, 1931 Maryland 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f sl Maryland Anne Arundel Annapolis 1 XX/es 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Steele Avenue 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

120 Yes 2 □ No If Yes, Give Year or Dates. Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 11. Marital Status 14. Race - American Indian, þ 1 Never Married XX Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Chemical Engineer Civil Navy 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of ဂ Thomas Danahy Hazel Swietzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janeil Danahy/wife Department of Health a Important: If item 27 is any injury or other tra 11 Steele Avenue Annapolis, Maryland 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 9/25/2012 | Annapolis, Maryland 21. Signut of Juneral Service 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fall days disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner omplications from multiple Done fractures Sequentially list conditions, if any leading to immedicause. Enter Underlying as a conse uence of Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρţ in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death 1 Yes 2 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Myocardial 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy After this certificate Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗌 No M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 09/14/2012 FOUND 1030 AM Division 1 Yes Investigation Fall filled in by the within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hime Avenue Annapolis: Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certify 29d. Date signed (Month. Day. Year) um of person who completed cause of death (Item 23a) (Type, Print) MD 22 South Greene Baltimore MM 31. Date filed (Month, Day, Year) SEP 2 4 2012 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar				1ental Hyg	giene	0 00170	
			Registrar		Cer	tificate of E	Death		Reg. No.2	2 32479	
П	Physicia		1. Decedent's Name (First, Middle, Last)  Phyllis	Anne	Denit	-		2. Date of Dea	ber <sup>Day</sup> 19, 2	3. Time of Death 11:00 AM	
m	Medic Examir		4a. Facility Name (if not institution, give si				Location of Death		4c. County of		
- ord			Collington Episcopa			Mitchel			Prince George's		
	Funeral Director		5. Social Security Number 6. Sex 577–40–9362 1 Usual Residence of Decedent	9= (	yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09/25/	(Year)	Birthplace (State or Foreign Country) England	
	land show dat	ρ	10a. State 10b. County	10	Oc. City, Town or Loc	cation				10d. Inside City Limits	
	Mary 28a-1 otifie	Director	Maryland   Prince Ge	eorge's	Mitchell					1 Yes 2 X No	
	ith the 23a or st be r		10e. Street and Number 10450 Lottsford Ro	had		10f. Zip Code 207:	2.1		10g. Citizen of Wha	at Country?	
	tems	Funeral		12. Was Decedent Ever		Vas Decedent of His	spanic Origin? (Spe			American Indian,	
Maryland 21215-0036	e filed within 72 hours after death with the Maryland ttal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	δ	1 ☐ Never Married 2 ☐ Married  3XX Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.		Yes, specify Cubar	Specify:	Rican, etc.)		White, etc. White	
15-(	72 hou n "nat ledica	Completed	15. Decedent's Edu (Specify only highest grad		(Give I	ent's Usual Occupa aind of work done d	ation u <i>ring most of worki</i>	ng	16b. Kind of Busin	ess/Industry	
212	iled within 72 Il Hygiene. other than '		Elementary/Secondary (0-12) 8th	College (1-4 or 5+)	Libra	NOT use retired)			Private	School	
pu	filed tal Hyg	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	, , , , , ,	,		
ryla	should be file and Mental I 7 is marked o raumatic eve	F			ods				opkins		
Ma	of Health and Ments of Health and Ments fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type Lyle R. Denit /		1.0		nd Number or Rura ew Drive		City or Town, State		
Baltimore,	of Hez of Hez fitem rothe		20a. Method of Disposition		20b. Place of Dispos		1		20c. Location - Cit		
limo	ment tant: I		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Md. Vet.		09/24	/2012	Cheltenha	m, Maryland	
Ball	permit. Page 1: Department of I Important: If it, any injury or of		21. Signature of Funer Source Company	7	6	Name and Addres	s of Facility Geo Hill Rd.	rge P. H Oxon Hi	Kalas Fun ill, Mary	eral Home P.A. land 20745	
H			23a. Path. Enter the disease, or complication shock, or heart failure. List only one	cause on each line.				r respiratory arre	est,	Approximate Interval Between	
~<	Physician Medical	Ò	Immediate Cause (Final disease or condition resulting in death)		REBROVASC	ULAR ACC	CIDENT			Onset and Death	
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	_ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):					75	
	ecutec and -trans	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a co	insequence off:						
0	cate be executed physician and s the burial-transit	dical	death, East	540 10 (01 45 4 00	risequence oi).						
8760	ificate ig phy as the	ı oo ı	IF FEMALE:								
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/M		3c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	f delivery Day Year	
, P.O.	es that the igned by be detai	by Ph	Part II. Other significant conditions conf Hypertensi		ot resulting in the ur	nderlying cause give	en în Part I.		١.	e to the cause of death?	
rds	require been s should	eted	Parkinson'					1 □ Y∈	,,	Probably 4 Unknown	
Division of Vital Records,	sician: The law is certificate has the			s Disease				24a. Was ar autops perfore	sy prior		
/ita	Physician: T this certifica ral director, p	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	2 ER/Outpatient	Otho	ce of Death (Check			~ )	
) of	ing Phy I. Viter this funeral o		27- Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, Ye	28b. Time of	28c. Injury work?	at 2		ence 6 Other (S w injury occurred	pecify)	
sior	I or Attending P s after death. I Director: After t d in by the funers	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm stre		res 2□No	196 Landin /04		D -12 1 1 1	
<u> </u>	al or A s after il Direc ed in by		4 ☐ Homicide determined	building, etc. (S)		st, lactory, office	ľ	City or Town,		Rural Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine 3 Certifying Nurse	ian: To the best of my line: On the basis of examination of the best of the be	ination and/or investi-	gation, in my opinior	. death occurred at	the time, date and	diplace, and due to t	he cause(s) and manner stated	
	Voit Voit		29b. Signature and title it certified			29c, License		25	9d. Date signed (Mo	onth, Day, Year)	
	,		30. Name and address of person who con	nnleted cause of death	(Item 23a) (Type Pr		47003		September	19, 2012	
X	46		William DuBoyce	MD 12158	Central	,	hellville	e, Maryl	and 2072	21	
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 1 201	2 32. Fegistrar's S	Signature .	are					

DHMH 17 Rev 06-2011

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		of Maryland / Department of Health and Mental Hygiene						
			Registrar  1. Decedent's Name (First, Middle, Last)	Cei	rtificate of Death		Reg. No. 2 U   6	32480			
I	Physicia Medic		CINTHIA D	AVIS		2. Date of De Month	Death 3. Time of Death 125 9 PM				
mark.	Examin	er	4a. Facility Name (if not institution, give street all PRINCE GEORGES HOSP		4b. City, Town, or Location		4c. County of Deat	h			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 1 Months Days Hours	er 24 Hrs. 8. Date of Bir Min. (Month, Da		hplace (State or Foreign			
	Director		S79-04-9387 Usual Residence of Decedent	XF 40 Yrs.		08/29/	11972	DC			
	yland f shored	ctor	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits			
	r 28a- notifij	Funeral Director	DC 10e. Street and Number	Washingto	On 10f. Zip Code		10 000 000	1 X Yes 2 □ No			
	with th	eral	3124 Berry Rd. NE		20018		10g. Citizen of What Co	,			
	death items ner mu	Fun	11. Marital Status 12. Wa	s Decedent Ever in U.S. 13. \ned Forces?	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No-	14. Race - Amer	rican Indian,			
036	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ed by	1 Never Married 2 Married 1	Yes 2 X No	1 ☐ Yes 2 🔀 No Specif		Specify: Black				
2-0	2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade com		dent's Usual Occupation kind of work done during mo	ost of working	16b. Kind of Business/				
121	within 7 giene. Ier than	Completed		lege (1-4 or 5+)	O NOT use retired) upervisor		Telecommur	vications			
р 2	be filed w ental Hygi <b>ked othe</b> <b>c event,</b> i	Be	17. Father's Name (First, Middle, Last)			ther's Name (First, Middle,		itcactoiiz			
ylaı	uld be file I Mental narked o natic eve	2	Bobby C. Davis			nry Jane Barr					
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Prin.  Mary J. Davis / mother		ng Address (Street and Num. Berry Rd • ¬ N			Code)			
nore	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once.		20a. Method of Disposition  1 M Burial 2 Cremation 3 Remove	ar from otate	natory or other place)	Date	20c. Location - City or				
Ħ	permit. Page 1: Department of I Important: If it any injury or of		4 ☐ Donetion 5 ☐ Other (Specify)  21. Signat Sector Funeral Sector ice Licensee		emorial Cem.  Name and Address of Fac						
ä	permit Depar Impor any in		Mark Str	There	6500 Allento						
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not enter on each line.	er the mode of dying, such a	s cardiac or respiratory arr	rest,	Approximate Interval Between			
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Fatal Arryt	mia			Onset and Death			
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876	tificate ng phy e as th	Med	IF FEMALE:								
9 x c	eath certificat attending ph	cian/	23b. Was decedent pregnant 23c. If ye in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year			
P.O. Box 687	the deay by the a	Physician/Me		Unknown	Other (specify)						
, P.O	requires that the des been signed by the s should be detached	by	Part II. Other significant conditions contributin	g to death but not resulting in the u	nderlying cause given in Par	t I. 23e. Did to	obacco use contribute to	the cause of death?			
ords	been should	letec	· · · · · · · · · · · · · · · · · · ·	14		24a. Was a		opsy findings available			
Records,	he law ite has vage 2	Completed				autop perfor 1 🗆 Yes	prior to c	ompletion of cause of			
ta	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?			ath (Check only one)	2 1 10 10 10 105	2 2 2 3 10			
Ž	Physic this o	은	1 ☐ Yes 2 No Hospital:	1 Nnpatient 2 ER/Outpatien Date of injury 28b. Time of	ot 3 DOA Other: 4 D	Nursing Home 5 Resid		5)			
o uc	nding ath. r: After re fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury	work?  M 1 \sum Yes 2		ow injury occurred				
Division of Vital	or Atte after de Directo	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At home, farm, strebuilding, etc. (Specify)	eet, factory, office	28f. Location (S City or Tow	treet and Number or Run n, State)	al Route Number,			
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	edical	29a. Certifier (Check (	the best of my knowledge, death on the basis of examination and/or invest	occurred at the time, date an	d place, and due to the ca	use(s) and manner as sta	ited.			
	To the H within 24 To the F complete	Me	only one 3 Certifying Nurse Practi	tioner: To the best of my knowledge,	death occurred at the time, d	ate and place, and due to the	ne cause(s) and manner as	stated.			
	<b>7</b> .≱ <b>6</b> 8		295. Signature and time of certifier		29c. License number	_	29d. Date signed ( <i>Month</i> ,	Day, Year)			
	457		30. Name and address of person who completed	d cause of death (Item 23a) (Type, P	1)0068 (		717				
			Ziba Shirani	3001 HOSPITAI	DR Cheve	Kly mo	20143				
	Stat Registra	e ir	31. Date filed (Month, Day, Year)	32. Registrar's Signature		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mort HUL Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death
Prince George's 9885 Greenbelt Road Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days 1 M 2 D Hours Min. Year 577-28-3634 93 **Director** Oct. 1918 Washington, DC Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Maryland Prince George's Lanham 1 X Yes 2 No 10f. Zip Code ö 10g. Citizen of What Country? by Funeral 23a 20706 United States 9885 Greenbelt Road ıral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. **African** Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 XNo Specify: American "natural", 3 ₺ Widowed 4 □ Divorced Completed Year or Dates. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Bureau of Engraving Employee Government Ith and Mental Hygien

27 is marked other the traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f and 2 should be fill Health and Mental Item 27 is marked 2 Mabel Powell John W. Mathews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 6th Street, SW #209B Washington, DC 20024 Ethel B. Norris - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lee's Crematory Sept 27, 2012 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John 2 Stever M00560 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ enn disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the a Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an has autopsy certificate 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: ျ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th Certificate: Natural 28c. Injury at injury 5 Pending work?
1 Yes 2 No Accident Investigation the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29h. Signature 29d. Date signed (Month, Day, Year) 9/21 35M of death (Item 23a) (Type, Print) 191TA PEUZ (WITHING ME) 21080

DHMH 17 Rev 7/2009

State Registrar 82. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No.  20 2 3 2 4  2 by Signar 1. Decedent's Name (First, Middle, Last)  2 Date of Death 3. Time of D											3248				
Physiciar Medical Examin				lle,Last) D DAVENPO	RT					2. Date of De Month Septemb	Day	Year		ime of Death	
*		4a. Facility Name (if	f not institutio	on, give street and n					ocation of De			c. County of D	eath		
Funeral	4	University H	<u> </u>	6. Sex	7. Age (In yrs.	last birthday)	Baltimo		If Under 24	Hrs. 8. Date of B	Birth (MM)	/DD/YYYY] 9.	. Birthpla	ce (State or	
Director		215-15-3		1X M 2 F	36	Yrs	Months	Oays		<sup>1in.</sup> 02/24	/197	6 Fo	oreign Ma Country	ce (State or ARYLAND )	
ž.	-	Usual Residence of 10a. State	Decedent 10b. County		I 10c City	, Town or Locat	ion			-	10d. Inside City Limits				
ne Maryland or 28a-f show any fied at once.		MD		ANNE'S		VENSVILI								Yes 2 X No	
Aarylar 28a-f s	Director	10e. Street and Nun	nber				10f. Zip C	ode			10g. Citi	izen of What (	Country?		
th the last		120 TENN	IESSEE			Lie w	216					TED ST			
eath wi	<b>—</b>	11. Marital Status  1 X Never Marrie	ed 2 Ma	arried 12. Was De Armed F	ecedent Ever in U Forces? 2  X  No					Specify Yes or Norto Rican, etc.)	10-	14. Race - Ar White, et		ndian, Black,	
rall, or	ă a	3 Widowed		orced If Yes, Give Ye or Dates:	ear	1	Yes 2X					opeony.	HITE		
2 hours		15. Decedent's Ed Elementary/Seco		cify only highest gra	ade completed) (1-4 or 5+)	16a. Deceder during m			n (Give kind o O NOT use r		16b. ł	Kind of Busine	ss/Indust	try	
orthin 7 ene.	Completed	12				CARPI	ENTER					CONSTR	UCTI	ON	
	ရှိ ရ	17. Father's Name (		•				- 1		me (First, Middle	,	Surname)			
212 ould be d Ments is even			RICHARD LYNN DAVENPORT    CAROL ANN SHINDLE   GAROL ANN SHINDLE   CAROL ANN SHINDLE   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, STECHARD L. DAVENPORT/FATHER   120 TENNESSEE ROAD, STEVENSVILLE, MD										tate, Zip	Code)	
MD and 2 sh alth and 27 in raumat	L	RICHARD  20a. Method of Disp		VENPORT/F		120 7				STEVENS		E, MD			
Baltimore, permit. Pages I ar Department of Hea Important: If iter injury or other tr		1 X Burial 2		n 3 Removal f	from State	crematory or oth	ner place)		<i>"</i>			•		•	
altim nit. Pa partmen sortant		4 Donation 5 21. Signature of Fur			511	EVENSVII				0/04/201					
			>	f /L		1106	SHAM	ROCK	ROAD	, CHESTE	<u>:R,_M</u>	ID 2161	.9	ME, P.A.	
Physician //Medical		23a. Part I. Enter the failure. List only	y one cause	on each line.							rrest, sho	ck, or heart		proximate Interval etween Onset and Death	
Examiner		Immediate Cause (F or condition resultin	Final disease g in death)		iphetamii a consequence o		morpn1	ne l	Lntox1	cation			_	Death	
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876( tificate ng phys as the b		IF FEMALE: 3b. Was decedent p			, outcome of preg birth		tal death	3	Ectopic preg	nancy		d. Date of delivers	very Day	Year	
Box 6876 e death certificate the attending phy ed for use as the b	Priysician/M	past 12 months?			nant at time of de		ner (Specify	_					,		
trucke de by the ached f		Part II. Other signif		9 Onki		esulting in the u	nderlying ca	use give	en in Part I.	23e. Did	tobacco i	use contribute	to the ca	ause of death?	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director. After this certificate has been signed by led in by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach by the funeral director.	o o									1 Ye	es 2	]No 3  P	robably	4 Vnknown	
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1 of Vi ling Physi After this funeral dir		27. Manner of Death	_	28a. Date (Mont)	e of Injury h, Day,Year)	28b. Time of Ir	· ·	: Injury a	at Work?	28d. Describe	how inju				
Sion Attendi r death. ector: by the f	3	1 Natural 2 Accident	5 Pend	ting stigation fd 9	-28-12	fd 5:50	) pm		2 <b>X</b> No	unknow					
Division of sopital or Attending I hours after death.  meral Director: After y filled in by the funer		3 Suicide 4 Homicide		d not be (Specify)	ce of Injury - At he found	on tra			aing, etc.		State)	300 W. I		bute Number, City	
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To the How within 24 h To the Fun completely	2	one) 2 🗸		miner: On the basis and manner :		nd/or investigati		icense n		at the time, date		ce, and due to Date signed (/			
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Betty Marie Dulany 9 :30 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospice alisbun NICOMI CO at the 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Months Hours 218-14-2407 1 □ M 2 🕇 F 87 12 15 1924 Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 X Yes 2 No Maryland Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 319 N. Division St. 21801 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give 1 Yes 2 XNo Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Linwood Taylor Flora Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph O. Dulany Son 11601 Shipwreck Rd., Unit 201, Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parsons Cemetery 9 22 2012 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland onatu e of Funeral Service Licensee Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death 4000 Parkinso disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year 2 INO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a, Was an

Physician Medical Examiner Examiner

Physician/

Medical

10a. State

Director

Funeral

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**Examiner** 

**Funeral** 

Director

28a-f show notified at

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Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic evenoce.

Page 1 and 2 should I ment of Health and M∈

Saltimore, Maryland 21215-0036

ms 23a or must be r

Examiner

the Medical

the attending physician and ched for use as the burial-tran been signed by after death.

Director: After this certificate has

Physician/Medical

þ

Completed

Certificate: To Be

Medical

27

IF FEMALE

25. Was case referred to medical

or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Ves 9 Unknown

24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No

26. Place of Death (Check only one

examiner?				_			sri orny orroy
1 ☐ Yes 2 🗷	No	Hospital: 1	ER/Outpatient 3		Other: 4	☐ Nursing H	lome 5 Residence 6 Other (Specify) Coasto
Manner of Death  Natural  Accident  Suicide	5 ☐ Pending Investigation 6 ☐ Could not be		28b. Time of injury		Bc. Injury at work? 1 \square Yes		28d. Describe how injury occurred
4 Homicide	determined	28e. Place of Injury - At he building, etc. (Specify		actory,	, office		28f. Location (Street and Number or Rural Route Number City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number H 684/3 29d. Date signed (Month, Day, Year) Sept 18 2012 Tunacolo Sheehan D.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tunavoli - Sheehan D.D. 10 Box 1733 Salisbury MD 21802

State Registrar 31. Date filed (Month, Day, Year) Registrar's Signatur

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Ernest Donoway 2012 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City. Town, or Location of Death AchidSULA SAL 13641 Numico Social Security Number If Under 1 Year If Under 24 Hrs Funeral 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours (Month, Day, Year) Director 213-22-9801 1 X M 2 D F 82 Sept. 26,1929 Maryland Usual Residence of Decedent .l Hygiene. i other then "natural", or itema 23a or 28a-f show vent, the Medical Evaminer must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 No Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7507 Madeline Circle 21849 USA 12. Was Decedent Ever in U.S Armed Forces? 1 0 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1950 Black. White, etc. à 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: 1952 3 Widowed 4 Divorced Completed White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Welder Metal Fabrication Be 17. Father's Name (First, Middle, Last) Should be file h and Mental H 7 Is merked ot 18. Mother's Name (First, Middle, Maiden Surname) 2 George W. Donoway Olive Pearl White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Lee Donoway/Wife 7507 Madeline Circle, Parsonsburg, Maryland 21849 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory Of Delmarva 9/21/2012 Delmar, Delaware 21. Signature of Funanti Service Lice 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 3171
IZIZ Old Ocean City Road, Salisbury, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Embolic disease or conditi resulting in death) Medical Due to (or as a consequence of) Examiner hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ig physiclan and as the burlel-trensit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day To the Hospital or Attending Physicien: The law towards within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached. 1 ∐ Yes ∠ L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vinknown 24a. Was an Were autopsy findings available prior to completion of cause of autonsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) ၉ 1 ☐ Yes 2 🖫 No Other: 1 Dinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO041211 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Fernando

31. Date filed (Month, Da

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and

Salisbury MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State		State of Ma	aryland		irtment of F t <i>ificate of E</i>			lental Hy	0	010	32485
		Registrar  1. Decedent's Name	(First, Middle, Las	t)		Cer	incate of L	Jean	<i>1</i>	2. Date of D	Reg. No. /	416	3. Time of Death
Physici Medi		John Edwa	ard Ewalo	1						Month 09	23	2012	10:00 a M
Exami		4a. Facility Name (if no	ot institution, give	street and number)			4b. City, Town, or	Locatio	on of Death			unty of Death	120.00 4
			or Drive				Hagerst					Washington	
Funeral Director		5. Social Security Nun 213-40-28		7. Age	(In yrs. last		If Under 1 Year Months Days	If Und Hours	der 24 Hrs. s Min.	8. Date of Bi (Month, D		9. Birth Co <i>u</i> r	place (State or Foreign etry)
		Usual Residence of		® M 2 □ F	71	Yrs.		_		10/28	/1940	Mary	land
land show	호	10a. State	10b. County	-	10c. City, T	own or Loc	ation						10d. Inside City Limits
Mary 28a-1 otifie	Director	Maryland	Washing	ton	Hag	ersto	wn						1 X Yes 2 □ No
th the 3a or the r	a l	10e. Street and Numb					10f. Zip Code					of What Cou	ntry?
ath wi	Funeral	656 Tudo	r Drive	12. Was Decedent E	ver in I.I.S	13 \	21742 /as Decedent of His		Origin? (Spe	rify Vas or No	U.S.		an Indian
6 er de or ite	by F	1 Never Married	d 2 🛣 Married	Armed Forces?		If	Yes, specify Cuba	n, Mexic	can, Puerto I	Rican, etc.)		Race - Americ Black, White,	
003 Irs aff ural", I Exa	ed	3 Widowed 4	Divorced	If Yes, Give Year or Dates.		1	Yes 2 No	Speci	ify:		Spe	ecify: W	hite
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ithin ithan	000	Elementary/Secon	dary (0-12)	College (1-4 or 5	+)		NOT use retired)				Re	ligion	
Id 2	Be	17. Father's Name (Fir	st, Middle, Last)	<u> </u>				18. Mo	other's Name	(First, Middle			
/lar	은	Edward	Lewis Ew	ald				A	Anna K	rapf			
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam		19a. Informant's Nam					g Address (Street a						
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nord nt of h		1 🔀 Burial 2 🗆	Cremation 3	Removal from State	cem	etery, crem	ition (Name of atory or other place			ate		ion - City or To	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.		4 L Donation 5	Other (Specify		Rest		n Cemete			7/12		stown, eral C	Maryland
any any		> 5.M.	IL Su	kn			01 Penns						•
		23a. Part 1. Enter the	e disease, or corn	cations that caused te cause on each line	the death. [	Oo not ente	the mode of dying	g, such a	as cardiac o	respiratory a	rrest,		Approximate Interval Between
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Medical Examiner		resulting in death)	•	a. Due to (or as a	consequen	ce of):	1		1	,	4	,	0
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ed	Examiner	cause. Enter Underly Cause (Disease or inj	ing	Due to (or as a	consequen	ce oi):			ι				
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Hecords, P.O. box 68/7 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Pr	Part II. Other signification	ant conditions co	ntributing to death bu	ıt not resulti	ng in the ur	derlying cause give	en in Pa	ırt I.	23e. Did 1	obacco use d	contribute to the	ne cause of death?
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Nord In req 1s bee 2 sho	plet									24a. Was		4b. Were auto	osy findings available mpletion of cause of
DIVISION OT VITAI HECONGS, tall or Attending Physician: The law requires rs after death.  al Director. After this certificate has been signed in by the funeral director, page 2 should be an income.	Completed										ormed?	death?	
cian: cian: ector,	Be	25. Was case referred examiner?	/ h	Hospital:					eath (Check	only one)			
Physical direction	임	1 Yes 2 2	No '	1 Inpatie		Outpatient		4 📖				Other (Specify	)
nding ading th. After e fune	Certificate:		5 Pending Investigation	(Month, Day,		injury	28c. Injury work? M 1 🔲	Pi Yes 2		8d. Describe	now injury oc	currea	
Atter Atter er dea ector by th	Ji ji		6 Could not be determined	28e. Place of Injur		, farm, stree						mber or Rurai	Route Number,
LIN Ital or Its after al Dir Ied in			/	building, etc.	(Specify)					City or To	vn, State)		
DIVISION Of VITAI HECC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 (Check 2	J Medical Examir	ician: To the best of r ner: On the basis of ex	amination an	id/or investi	gation, in my opinio	n, death	occurred at	the time, date	and place, and	due to the car	use(s) and manner stated.
o the ithin 2 the omple	ž	only one) 3 L 29b. Signature and titl	Certifying Nurs	e Practitioner To the	best of my k	nowledge, o	death occurred at the	ne time, o	date and plac	e, and due to	the cause(s) a	nd manner as a	stated.
FSFō		D L	11000	11 1.	(W)	ha	1 >	?/	73		Co 1	gried (IVIOITAI),	) U ~ ! \
		30. Name and address	s of person who c	ompleted cause of de	ath (Item 23	a) (Type, Pr	int)	. 0	· )		xcy, t	inh	21, 201
W-6		Fred	enc l	+ an	55 r	5 10	11 40	110	me	elice	Con	Qu)	Rel
Sta Registr		31. Date filed (Mont	EP 38 21	32. Pagistrar	's Signature	1 1	- 41 1		1/	A 4		1 1 . ^	D 21742
Registr	aı			A. Carlotte	The same of		N. Allen		1+	UCIC	tuw	( W	17 21 (10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32486 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harvey James Era, Sr. 1851 2012 eptember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death nda Social Security Number Age (In yrs. 93 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Hours Min Oct. 20, 1918 Mary land 214-07-8919 Director Usual Residence of Decedent or items 23a or 28a-f shov 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 X No Maryland Dorchester East New Market 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3754 Warwick Road 21631 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 X Yes 2 No 1941-Black White etc. þ permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examit 1 Never Married 2 X Married If Yes, Give 1 ☐ Yes 2 X No Specify. 1945 Specify: 3 - Widowed 4 - Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Waterman Seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph George Era, Sr. Elizabeth Agnes Whitely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alva J.Era/Wife 3754 Warwick Road, East New Market, MD 21631 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5 Other (Specify) Our Lady Of Good Counsel: 9/24/2012 Secretary, Maryland 22. Name and Address of Facility
Zeller Funeral Home, P. 0. Box 207 21. Signature of Juneral Service Wen ee Part 1. Enter the disease, or compleshock, or heart failure. List only one Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final eath Physician/ disease or condition resulting in death) nari Medical Due to (or as a nsequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the hurial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Other (specify) Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

24 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

N. VYCE; MD 300 BYRN ST. CAMBRIDGE, MD 21613

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death **Physician** 25 raa -2012 /Medical 4b. City. Town, or Location of Death County of Daath 4a Facility Name (If not institution, giva street and number 4c. Examiner 5. Social 7. Aga (In yrs. last birthday) 8. Data of Birth Security Numbar 6. Sax Birthplaca (Stata or Foreign Country) Funeral Months Days Hours Min 1 M 2 PF Director Usuel Rasidence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Merylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits A Heelth and Mentel Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28s-f ahov other traumatic event, the Medical Examiner must be notified at 1 Has 2 □ No **Funeral Director** 10e, Street and Number 10f. Zip Coda 10g. Citizan of What Country? 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 No 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian Black, White, etc. 1 ☐ Nevar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yas 21 No Specify: è Specify: WHITE 3 ₩idowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 17. Fathar's Name (First, Middla, Last) Name (First, Middle, Maidan Sumama) Be 19a. Informant's Name/Ralatienthip (Type, Print) 19b. Mailing Address (Straat and Number of Rural Routa Numbar, City or Town, Stata, Zip Coda) 8 0,111021155 20b. Placa of Disposition (Nama of cematery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 70 Department of Important: If it 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State ō 11monium, MIL injury Doloney 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee neral tome 311 S. Main St. Federalsburg, MD 21632 23a. Part1. Entar tha diseese, or complications that causad the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona cause on eech line. Approximate Interval Between Onsat and Death **Physician** Immediate Causa (Final disaase or condition rasulting in daath) /Medical orimone Examiner Due to (or as e consequance of): Physician/Medical Examiner Dhy+ eral Director: After this certificate hes been signed by the ettending physician end filled in by the funeral director, page 2 should be deteched for use as the buriel-transit or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immadiata causa. Enter Undarfying Causa (Disaase or injury that initiated evants rasulting in death) Last Due to (or as a consaquence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha causa of death? 2□ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformad? 1 Yes 2 12 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 2**□**₩6 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Presidence 6 Other (Spacity) 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurrad 28b. Tima of within 24 hours efter death. To the Funeral Director: After 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be datarminad 3 Suicide 28a. Place of Injury - At home, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 29a. Certifiar 1112 Certifying Phyaician: To tha best of my knowladge, death occurred at the time, date and place, and due to the cause(s) and manner as stetad. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and dua to the cause(s) and manner stated. To the 29b. Signature and titla of certifiar 29d. Date signed (Month, Day, Year) DOCK 30. Nama and addrass of person who complated cause of deeth (Item 23a) (Type, Print) OOK 31. Data filad (Month, Day, Yaar) . Ragistrar's Signetura State B 8 2012 Registrar

DHMH 16 Rev 6/95

				pe or Print in								
	Tor AMFND#29c per Phy State of Maryland / Department of Health and State 9/25/2012 AACO HEALIH DEPT. CMH Certificate of Death					Reg. No. 2012 32488						
Physician/			Decedent's Name (First, Middle, Last)  -	1. Decedent's Name (First, Middle, Last)			2. Date of D			Death Day Year		Death
	Medic	cal	Leonard J. Fearon					Sept.	18,	2012	7:10	A M
	Examir	ier	4a. Facility Name (if not institution, give stree				or Location of Dea	th	4	c. County of Death		
	Funeral		Washington Adventis 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Takoma If Under 1 Year		Prince George			orge's	r Foreign
	Director		100−28−1309 1 🖫 M Usual Residence of Decedent		Yrs.	Months Days	Hours Min	Apr. 1		Cou	York	
	leath with the Maryland tems 23a or 28a-f sho er must be notified at	Funeral Director	10a. State 10b. County		ity, Town or Lo						10d. Inside Cit	•
		D I	MD Prince Geoi	ge's		10f. Zip Code	owie		100 0	Citizen of What Cou	1 X Yes	2 🗆 No
		eral	16022 Philmont Lane			1	0716		l log. c	USA	antry:	
		To Be Completed by Fun		Vas Decedent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	-	14. Race - Amer		
36	after of		1 ☐ Never Married 2 🔏 Married	Never Married 2 1 Married 1 1 Never Married 1 No 17						Black, White Specify: B1a		
21215-0036	ours atura		3 Widowed 4 Divorced  15. Decedent's Educati	ear or Dates.								
715	72 h an "n Medi		(Specify only highest grade co	mpleted)	(Give	dent's Usual Occup kind of work done OO NOT use retired	during most of wo	orking	16b.	Kind of Business/l	ndustry	
22	s 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. of Heath and Mental Hygiene. If tem 27 is marked other than "natural", or items 23a or 28a-f show ir other traumatic event, the Medical Examiner must be notified at		Elementary/Secondary (0-12)	College (1-4 or 5+) 5		ronics Er		_	Fed	eral Gov	ernment	
Maryland			17. Father's Name (First, Middle, Last)					,				
			19a. Informant's Name/Relationship (Type, P. Doris Fearon	rint)	19b. Mail 16022	ng Address (Street Philmont	and Number or R Ln.Bowi	ural Route Numb .e, MD 2	er, City o	or Town, State, Zip	Code)	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕅 Remo	20b.		osition (Name of matory or other place	ce)	DateUNK	20c. l	Location - City or 1	own, State	
ţ	t. Page tment c tant: If jury or		4 Donation 5 Other (Specify)	Jac	cksonv:	ille Nat'	1 Cem 10	•		cksonvill	le, FL	
Baj	permit. Page 1 Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee		2	2. Name and Addre	ess of Facility Be. rain Hwy	all Fun∈ • Bowie.	eral MD	Home 20715		
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the dea						20715	Approximate	,
	Physician/	2 3	Immediate Cause (Final disease or condition	ise on each line.	2 155	is				1	Interval Betw Onset and D	
-	0 22	dical Examiner	resulting in death)	File to (or as a cons		4						
			Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):									
			cause. Enter Underlying Cause (Disease or injury									
			that initiated events c									
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924	rtificating pheas the	/Me	IF FEMALE:									
that the death certificate be death certificate be death certificate be death certificate be detached for use as the bring in the bast 15 mm large.    Physician		in the past 12 months?	23c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)			су	1		23d. Date of delivery  Month Day Year		oor.	
m.	e e d	ysic		Unknown	death 51	☐ Other (specify) _				Month	Day 16	ear
P.0		y P	Part II. Other significant conditions contribu	iting to death but not re	sulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to t	he cause of de	ath?
S,	uires in sign	ed b						1 🗆	1 Yes 2 1 No 3 Probably 4 Unknown			
Š	iw required as bee	Medical Certificate: To B						24a. Was		24b. Were auto		
Re	The Is ate ha page								ormed?	death?	ompletion of ca	use or
ta	iician: The certificate rector, pag		25. Was case referred to medical examiner?				ace of Death (Che					
Ž	I or Attending Phys after death. Director: After this d in by the funeral di		1 ☐ Yes 2 ☑ No Hospit  27. Manner of Death 2	1 1npatient 2	T .		4 ☐ Nursing I	lome 5 Res	idence	6 ☐ Other (Specif	()	
Division of Vital Records,			27. Manner of Death 28a. Date of injury 28b. Time of injury at work? 28c. Injury at work? 28d. Describe how injury occurred work? 3 Suicide 6 Could not be									
.≥			4 Homicide determined	Be. Place of Injury - At he building, etc. (Specify	y) 			City or To	wn, State			er,
			29a. Certifier (Check only one)  1 Certifying Physician: 2 Medical Examiner: 0 3 Certifying Nurse Pra	n the basis of examinatio	n and/or inves	tigation, in my opinio	on, death occurred the time, date and p	at the time, date place, and due to	and place the caus	e, and due to the ca e(s) and manner as	use(s) and man stated.	ner stated.
			29b. Signature and title of certifier			29c. Licenso	e number	0601+2 00	29d. Da	ate signed (Month, 9 9-15	Day, Year)	-
Ċ.	4441		30. Name and address of person who comple	Aldrip	9	Print) S. 3-	1 V~iv	かりとり	. }	3200 5	er S L	
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	becker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09/22/2012 Physician/ 11:30P M Amy Elizabeth Fluker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1616 Perryville Road Cecil Perryville 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 05/26/1969 Alabama Director 215-06-3169 1 □ M 2 🗶 F 43 show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland Cecil Perryville 1 🗆 Yes 2 🛣 No 10g. Citizen of What Country?  $U \cdot S \cdot A \cdot$ 0 10f. Zip Code must be Funeral 1007 Cedar Corner Road 21903 23a 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iten Examiner r 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 🔀 No permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) n and Mental F မှ Mary Beth Calary Edward D. Triplett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1007 Cedar Corner Rd. Perryville, MD 21903 19a. Informant's Name/Relationship (Type, Print) Randall Fluker Jr. (husband) of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other plac RA Ferris & Co. 20a. Method of Disposition 20c. Location - City or Town, State West CHester, Department of F Important; If ite any injury or otl 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 09/24/2012 4 Donation 5 Other (Specify) Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. S.Washington St Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Cirrons Ph, i i n JVEr disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 X Prairies Home ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Check 3 Certifying Nurse, Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHA HNA WAZ

AUGUSTINE

HERMAN HWY

D0062190

I SUITE A, CHESAPEAKE

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ľ	State of Maryland	J / Department of H Certificate of D		201	2 32490		
			1. Decedent's Name (First, Middle, Last)		2. Date	Reg. No ( )	3. Time of Death		
	Physicia Medic	cal	DORA GAMMIL		Ment	Day Ye	12 4:45 AM		
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or		4c. County of [	Death A Data IN 5		
P	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday) If Under 1 Year	If Under 24 Hrs. 8. Date	of Birth AM	Birthplace (State or Foreign		
	Director		343−18−1004 1 □ M 2 ဩ F 94  Usual Residence of Decedent	Yrs. Months Days		h, Day, Year) 23, 1918 II	Country)		
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director		Town or Location			10d. Inside City Limits		
			MD Anne Arundel Croft				1 ☐ Yes 2 🛣 No		
			10e. Street and Number 1710 Tipton Dr.	10f. Zip Code <b>21114</b>		10g. Citizen of Wha	t Country?		
			11. Marital Status 12. Was Decedent Ever in U.S.		spanic Origin? (Specify Yes on Mexican, Puerto Rican, etc		American Indian,		
36			1 Never Married 2 Married Armed Forces? 1 Yes 2 M No If Yes, Give	If Yes, specify Cubar		Didox, V	/hite, etc.		
0			3 ☐ Widowed 4 🖾 Divorced Year or Dates.	16a. Decedent's Usual Occupa		Specify: W			
215	iin 72 t ie. <b>han "n</b> <b>e Medi</b>		(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done du life. DO NOT use retired)	uring most of working	16b. Kind of Busine	·		
121	d with Hygien Ither th		17. Father's Name (First, Middle, Last)	Librarian		Health Ca	re		
Baltimore, Maryland 21215-0036	be filed lental Hy rked oth ic event		Paul Cronk		18. Mother's Name (First, Min Mabel Thom	ddle, Maiden Surname)			
lary	should be and Ment is marked raumatic			19b. Mailing Address (Street ar	nd Number or Rural Route Nu	ımber, City or Town, State	Zip Code)		
e, ⊾	and 2: Health tem 27 other tr		Paul Gammill / Son	1710 Tipton Dr					
nor	permit. Page 1 a Department of H Important: If ite any injury or ott		1 Burial 2 🔀 Cremation 3 🗌 Removal from State cen	ce of Disposition (Name of netery, crematory or other place		20c. Location - City			
altir	mit. P. partme portan / injur.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Senior Linensee	co Crematory  22. Name and Address	9/25/2012 s of Facility Bea11 Ft	Baltimore	, MD		
m	permi Depar Impo any ir		1 (lents)	6512 NW Cra	ain Hwy., Bo	owie, MD 20	715		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between						
	Physician/ Medical	ř	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequent of the consequence of the consequency of the conseque		4		Onset and Death		
	Examiner		LIDNIC MASSEL CRIENT						
	sit of	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		Cause (Disease or injury that initiated events c. Due to (or as a consequence of):						
09	death certificate be executed ne attending physician and ed for use as the burial-transi	dical	d						
3876	ertificat ling ph	Physician/Medical	IF FEMALE:			- C: .			
Box 687	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea	leath 3 Dectopic pregnancy		23d. Date of Month	delivery Day Year		
В	the de by the rached	hysi	9 Unknown 9 Unknown	and the state of t					
, P.O.	ss that igned l	þ	Part II. Other significant conditions contributing to death but not resulti	ing in the underlying cause give	200.	Did tobacco use contribute			
Division of Vital Records,	require been s should	Completed	Minary Tract inhetion				Probably 4 🖾 Unknown		
oce.	sician: The law i certificate has k lirector, page 2 s	duc	autopsy				autopsy findings available to completion of cause of 1?		
<u>а</u> н	ian: Tr rtificat ctor, pi		25. Was case referred to medi al  26. Place of Death (Check only one)						
<u> </u>	hysic this ce al direc	욘	examiner?  1   Yes 2   No   Hospital:   Other: 4   Nursing Home 5   Residence 6   Other (Specify)						
0 0	ding F th. After	Certificate:	27. Manner of Death  1 M Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year)	Bb. Time of 28c. Injury a 28c	es 2 No	be how injury occurred			
Sio	m (n — 2	iji	3 Suicide 6 Could not be 28e. Place of Injury - At home		28f. Locati	on (Street and Number or	Rural Route Number,		
2		- 1	building, etc. (Specify)			Town, State)			
:		Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
;	To the comp	≥	only one) 3 $\square$ <b>Certifying Nurse Practitioner:</b> To the best of my keep 29b. Signature and title of certifier	29c. License r		29d. Date signed (Mc			
			> Ullus o mu	MD D	0062395	9/2	4/12		
HI	,		30. Name and address of person who completed cause ordeath (Item 23		11350 (0-	LA. D. 304	Nan Odmica		
AT I	State	е	31. Date filed (Month, Day, Year) 32. Bigistrar's Signature		VIIEB GO	m DURME	MD 21061		
	Registra	r	SEP 25 2012 Serona &	1. park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year/Z Month A Physician/ oger Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-52-8784 Director 1**X** □ M 2 □ F 63 1/31/1949 MARYLAND Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 ☐ Yes 2X No MARYLAND ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 741 HILLTOP ROAD 21012 UNITED STATES items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status er than "natural", or iter the Medical Examiner 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 Widowed 4 Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien is marked other t CONTRACTOR HOME IMPROVEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLEED GALLION MABLE L. TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra ROGER GALLION II/SON 741 HILLTOP ROAD, ARNOLD, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Page 1 CHESAPEAKE CREMATION CENTER 1 Burial 2 XCremation 3 Removal from State 9/20/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE 814 BESTGATE ROAD, ANNAPOLIS, MD 21401 21. Signature of Suneral Service Licensee art 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ END STAGE DISEASE Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 🗶 No မ 1 Nanpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature a 29c. License number

Syl

DHMH 17 Rev 06-2011

State

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32492 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 24/2012 Nancy Sue Garcia Medical  $11:00A^{M}$ 4a. Facility Name (If not institution, give street and number)
Harford Memorial Hospital **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Havre de Grace 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Texas 8. Date of Birth Funeral 1 □ M 2 🂢 F 75 Months Days Hours Min. (Month, Pay, Year) 7 449-50-7319 Director Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Harford Havre de Grace 1 X Yes 2 No 10e. Street and Number 505 Congress Avenue Apt.410 10g. Citizen of What Country? 10f. Zip Code 21078 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 🗆 Widowed 4 🔀 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clarence Holt Sarah Lucille Moore 19a. Informant's Name/Relationship (Type, Pri(t) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Lynn Schwàrz 326 Hill Court, Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RA Ferris & Co. 09/25/2012 Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. 23 S. Washington St, Havre de Grace, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months
1 Yes 2 No Pregnant at time of death Month Day / the ε hed fα signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Mann eath 28c. Injury at Certificate: 28b. Time of 1 Natural 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 To the P only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certif of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	artment of Health and l artificate of Death		giene Reg. No. 2016	2 3249		
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month				
-	/Media	al	James Hiram Garber	T	Septem	mber 20, 2012 4:30 P M			
	Examir	er	4a. Facility Name (If not institution, give street and number)  998 Crystal Rock Road	4b. City, Town, or Location of Death	n	4c. County of Death	1		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign		
ь	Director	Director		Months Days Hours Min.	05/14/1	938 Penr	untry) nsylvania		
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits		
	Mary a-f sh		Maryland Calvert Lusby				1 ☐ Yes 2 🔀 No		
	or 28		10e. Street and Number	10f. Zip Code	1 -	10g. Citizen of What Co	untry?		
	s 23a		998 Crystal Rock Road	20657		Jnited Stat			
	be filed within 72 hours after death with the Maryland stal Hyglene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be redflind at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	rican Indian, , etc.		
5-0036	ours a	Ş	3 BHWidowed 4 □ Divorced If Yes, Give Year or Dates: 1953–1974	1 □ Yes 2 🕅 No Specify:		Specify: Wh	ite		
5-0	72 hc	Be Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work	king	16b. Kind of Business/I	ndustry		
12	within ene. <b>than</b> '		Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)  lice Officer		IIC C	•		
5	i filed I Hygi other ent, I	Ç	17. Father's Name (First, Middle, Last)		ne (First, Middle, i	US Governm Maiden Surname)	ent		
Maryland 2121	2 should be filed w n and Mental Hygie is marked other t raumatic event, th	To B	Charles Garber	Ruth Phi	illips				
Jar	2 sho and is ma			ing Address (Street and Number or Ru			ip Code)		
e)	as 1 and 2 should b of Health and Ment I Item 27 is marked r other traumatic e	1		Crystal Rock Road,					
altimore,	Pages nent of int: If its iry or o		1 Durial 2 La Cremation 3 Li Removal from State	osition (Name of matory or other place)		20c. Location - City or T	•		
<b>=</b>	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signaty • of Funeral Service Licensee	an Crematory 09/21 2. Name and Address of Facility Ra		Alexandria, V al Home, P.A.	irginia		
ñ	Deg any		Thechael Keven Harding in	P.O. Box 600, Lusby,	Maryland 2	0657			
			23a. Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between						
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. COUN COUNCER.						
4	/Medical Examiner		Due to (or as a consequence of):						
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	ecuted and transi	Examiner	Cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
ρĊ,	ificate be executed physician and s the burial-transit		Due to (or as a consequence of):						
6876U	eath certificate be executed attending physician and for use as the burial-transit	edical	d						
X Q Q	th cert	Physician/M	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 □ Live birth 2 □ Fetal death 3	T Setopia programa		23d. Date of deli	very		
ם	e deal the att	sicia		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year		
<u>7.</u>	that the		Part II. Other significant conditions contributing to death but not resulting in the u	Inderlying cause given in Part I	23e Did tol	pacco use contribute to	the cause of death?		
vital Records,	quires in sign	d by		and on the second secon		es 2 No 3 Pro	/		
ပ္သ	aw red	plete			24a. Was a		opsy findings available		
<u> </u>	The cate has page	Completed			autops perforr 1 ☐ Yes	ned? death?	ompletion of cause of 2 □ No		
VIE	or the respital or Attending Physician: I he law requires that the death certifuling 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Be	25. Was case referred to medical examiner?		th (Check only on				
5		Certification: To	1 Yes 2 Mo Hospital: 1 Inpatient 2 ER/Outpatient 3 Do Other: 4 Nursing Home 5 Mesidence 6 Other (Specify)  27. Manper of Death 28a. Date of Injury. 28b. Time of 28c. Injury at 28d. Describe how injury occurred						
DIVISION			27. Manyer of Death						
<u>S</u>		tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (St	reet and Number or Rui n. State)	ral Route Number,		
ב	pital o		Only of Young, State)						
	e Hose 24 ho e Fune letely i	Medical	29a. Certifier (Check only one)  1	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)		
	Vithin vithin To the comp	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month	, Day, Year)		
	1		How Ollin )	D17324		September 21.	2012		
1	0 KW		30. Name and address of Jerson who completed cause of death (Item 23a) (Type,			- Product 219	<u> </u>		
	Stat	e.	Raymon A. Noble, MD 228 Merrimac Court, Pr 31. Date filed (Month, Day, Year) 32. Registrar's Signature	rince Frederick, MD 20	678				
	Registra	ar	31. Date filed (Month, Day, Year) SEP 2 2012  Denous 32. Registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Henry Good Medical 04 2017 10:14 М 4a. Facility Name (if not institution, give street and number Examiner City, Town, or Location of Death 4c. County of Death alisbury, md HOSDICE Diconico **Funeral** Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Hours (Month, Day, Year) 215-20-4284 Director 1 **X** M 2 □ F Yrs. 87 July 11, 1925 Maryland 28a-f shov Depertment of Heelth and Mental Hygiene. Important: in Items 23a or 28a-f sho any Injury or other traumetic event, the Mechael Evantiver must be notified at gones. 10c. City, Town or Location Director 10d. Inside City Limits Maryland Somerset 1 ☐ Yes 2 ☐ No Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14514 Benjamin St. 21822 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No 1943

If Yes, Give + 0 1046 Black, White, etc. 1 Never Married 2 Married ģ Pege 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🖾 No Specify: Completed 3 Divorced Year or Date to 1946 Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 H.S. Grad. Baltimore, Maryland 2<sup>.</sup> Park ranger State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Martin Good Grace Kitchen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna R. Good/spouse 14514 Benjamin St. Eden, MD 21822 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Denton Cemetery 9/29/2012 Denton, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South 2nd Street Denton, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Pulmonary Obstructive DISCASE Onset and Death disease or condition resulting in death) 4cars Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Opisease or injury Due to (or as a consequence of): signed by the attending physiclen end d be detached for use es the burlal-transit Exami Hospitel or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by is certificate hes been si director, page 2 should i 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate hes autopsy performed? Yes 2 No 2 1 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number # 68 413 Junacole Sheekan D.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)
Thinaloll-Sheenan Do. 10 Box 1733 Salisbury: MD 21802

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles H. Hurst 5:30 P. M Medical September 18, 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert 3813 12th Street Chesapeake Beach 5. Social Security Numbe **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 207–36–6034 1 🔀 M 2 🗆 F 65 Dec. 18, 1946 Pennsylvania Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event any injury or other traumatic event. 10a. State Director 10c. City, Town or Location 10d. Inside City Limits Calvert Chesapeake Beach MD 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3813 12th Street 20732 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1√2 Yes 2 □ No If Yes, Give 1966–1968 Year or Dates. 1 Never Married 2 Married Black, White, etc. 1 Yes 2 XNo Specify: White 3 🗌 Widowed 4 🗌 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Computer Science Project Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LeRoy Howard Hurst Eleanor Strain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Hurst/Wife 3813 12th Street, Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Georgetown University Sept. 18 4

✓ Donation 5 ☐ Other (Specify) Washington, D.C. Medical Center Signalure of Fun yal Service License 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sici\_n/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** and Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BD51722

State Registrar

DHMH 17 Rev 06-2011

KM

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A+iGCOH

31. Date filed (Month, Day, Year)

SHILL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stake Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Suzanne Stults Hollenshead 23,2012 224 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Washington** Meritus Medical Center Hagerstown Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 72 158-30-0753 **Director** 1 □ M 2 🗰 10/25/1939 New Jersey permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1406 Outer Drive 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces

1 ☐ Yes 2 D No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ρ 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ JOhn Albert Merchant Stults Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifton G. Hollenshead / Spouse 1406 Outer Drive, Hagerstown, MD 21742 hod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Rest Haven Cemetery 9/28/2012 Hagerstown, MD Signat Funeral Service 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ ulmonary disease or condition Medical resulting in death) as a consequence Examiner 5-cite dially file conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detended for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 L No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0045563 Name and address of person who completed cause of death (Item 23a) (Type, Print) 12916 Conamar Prive Suite 204, Hagerstown, Maryland 21742 Theodoru, MD

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **9** Emma Mae Hobbs **Medical** 2012 10:18 a™ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hartlev Hall Nsq & Rehab Pocomoke City Worcester **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 3 - 5 - 1915 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 V F Months Min. Hours Country)
MD Director 212-18-0031 97 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🙀 Yes 2 □ No MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Completed by Funeral 708 6th Street 21851 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force
1 Yes 2 Black, White, etc. 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify Speci**B**lack 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lloyd Aydelotte Mary Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oleeta Dickens/Great Niece 9525 Hempel Cove Blvd, Windermere, FL 34786 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion\_UM\_Cem 9-22-2012 Pocomoke City, MD Mt 21. Signa are of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 NO Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 54422 9-13-2012 SARAD BARAL.

State

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DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month

egistrar's Signature

2185

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPT 1 7 Day 20<sup>Year</sup>2 JARALYN LOUISE HOUGH 3:10P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY 20320 BUCKLODGE ROAD BOYDS If Under 1 Year If Under 24 Hrs. Social Security Numbe 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Min. **Director** 1 □ M 2 MF 444-36-4967 75 08/19/1937 OK ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMERY BOYDS 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20841 USA 20320 BUCKLODGE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event than "natural", or Completed by 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DIRECTOR PRIVATE SCHOOL EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည VIRGINIA S. WILLIAMS HOWARD EMERSON THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAMMET HOUGH / 20320 BUCKLODGE ROAD, BOYDS, MD 20841 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BOYDS PRESBYTERIAN 09/27/2012 BOYDS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of an eal S-rvice Light BOX 86 P.O. HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC ADENOCARCINOMA 6 Medical resulting in death) Due to (or as a consequence of) Examiner MONTH RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ CANDIDEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed VRE BACTEREMIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 🗹 No DVT 1 🗆 Yes 1 Yes 2 No 25. Was case referred medical To Be 26. Place of Death (Check only one) examiner? Other: 2 🗹 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29b. 29d. Date signed (Month, Day, Year) 73109 MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHANNON O'CONNOR, MD 6420 ROCKLEDGE DR., BETHESDA, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Josephine Marcella Hines September 28 2012 2:22 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Lutheran Village Healthcare Carroll Westminster 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Hours Dec. 29 1914 Baltimore, MD Director 97 213-03-7445 Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director MD Carroll Westminster 1 Types 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 St. Luke Circle 21158 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Design & Pattern Maker Perfect Garment Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Anna Konopocka Philip Kosiorek permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1102, Shepherdstown, WV 25443 John Hines, Jr. - Executor 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith Cem. 10/2/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA ne 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pitysiciaiu disease or condition resulting in death) 120 TO Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an 24b Were autopsy findings available prior to completion of cause of autopsy perform death? 1 🗌 Yes 2 - No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: ၉ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Munna of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident ☐ Suicide s after death | Director: A d in by the f Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the careful of the careful o only one 29c. License number 2 29d. Date signed (Month, Day, Year)

State Registrar . Date filed (Month, Day,

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ sept. 3:45 AM Frances Hines Mary 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis La Plata Center La Plata Charles 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours 0 2 / 2 7 Months Director 235-56-0417 West 1939 Virgini Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits or 28a-f MD Charles La Plata 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral l Magnolia Dr. 20646 United States items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ori ģ 1 Never Married 2 Married 72 hours after Yes Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural", Completed 3 XWidowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' School Elementary/Seconday (0-12) College (1-4 or 5+) 12 Co. Public Teacher Aide P.G. other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lawrence Williams Frances Poling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5507 Joan Lane, Temple Hills, MD 20748 Michael Hines/Son Baltimore, 20a. Method of Disposition Department of h 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or o cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro 09/29/12 Crematory Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond Funeral Svc., P.A. M01517 5635 Washington La Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final The Onset and Death Physician/ 101 disease or condition resulting in death) ► Medical Due to (or as a consequence of) Examiner Demente Sequentially liet conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) senues Hospital or Attending Physician: The law requires that the death certificate be executed anonder the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 

Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day the g Unknown g Unknown ģ signed k Part II. **Other** s**ignificant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has director, page 2 autopsy performed? Yes 2 No death? 1 Yes 2 🗌 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work s after death death Accident Investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

the

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Registrar

State

29a. Certifier

(Check

6934

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2012

lvd

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)

Motton

Suite

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c, License number

GIEN BUPPIC